

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 05 IOM "Dying in America" Report
- 06 Designation of Specialty Societies for Representation in the House of Delegates
- 07 Supporting Autonomy for Patients with Differences of Sex Development
- 08 Medical Reporting for Safety Sensitive Positions

CC&B Report(s)

- 01 Membership and Representation in the Organized Medical Staff Section - Updated Bylaws
- 02 Bylaw Amendments Pertaining to Late Resolutions and Emergency Business

CEJA Report(s)

- 01 Collaborative Care
- 02 Competence, Self-Assessment and Self Awareness

Resolution(s)

- 001 Support for the Decriminalization and Treatment of Suicide Attempts Amongst Military Personnel
- 002 Living Organ Donation at the Time of Imminent Death
- 003 Study of the Current Uses and Ethical Implications of Expanded Access Programs
- 004 Addressing Patient Spirituality in Medicine
- 005* No Compromise on AMA's Anti-Female Genital Mutilation Policy
- 006* Effective Peer Review
- 007* Fair Process for Employed Physicians

* contained in Handbook Addendum

REPORT OF THE BOARD OF TRUSTEES

BOT Report 5-I-16

Subject: IOM “Dying in America” Report
(Resolution 6-I-15)

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 At its 2015 Interim Meeting, the American Medical Association (AMA) House of Delegates
2 referred to the Board of Trustees Resolution 6-I-15, “IOM ‘Dying in America’ Report,” introduced
3 by the Medical Association of Georgia. Resolution 6 asked our AMA to “support and advocate for
4 the recommendations of the Institute of Medicine ‘Dying in America’ report, which will improve
5 the quality of end-of-life care received by all patients.”

6
7 Testimony for this resolution supported the spirit of the IOM report in light of the recognized need
8 to improve quality of care at the end of life. However, testimony noted that the AMA had not had
9 the opportunity to vet the report thoroughly in light of existing AMA policies on relevant issues
10 and noted that endorsing the report in its entirety could have unintended consequences for AMA.

11 12 BACKGROUND

13
14 The overarching goal of *Dying in America* is to ensure that all patients “with advanced serious
15 illness who are nearing the end of life” have round-the-clock access to comprehensive care
16 provided by appropriately trained personnel in appropriate settings, in keeping with individuals’
17 values, goals, and preferences.

18
19 The report identifies five key domains in which action is needed: financing for comprehensive
20 care; quality measurement; professional education, licensure, and credentialing; interoperable
21 electronic health records; and public education about end-of-life care and advance care planning. In
22 each of these areas, the report recommends specific activities and defines accountability among key
23 stakeholders. (See Appendix A.)

24 25 *Financing for Comprehensive Care*

26
27 *Dying in America* calls for public and private payers to cover provision of comprehensive, high-
28 quality consistently accessible care that is “patient centered and family oriented”; consistent with
29 individuals’ values, goals, and preferences; and delivered by appropriately trained personnel
30 (Recommendation 1). Such care should include access to interdisciplinary palliative care. The
31 report further recommends that federal, state, and private insurance and health care delivery
32 programs “integrate the financing of medical and social services,” by supporting coordination of
33 care and use of financial incentives to decrease use of inappropriate emergency department or acute
34 care services, among other initiatives (Recommendation 4).

1 *Quality Measurement*

2
3 *Dying in America* recommends that organizations that deliver health care publicly report aggregate
4 measures of quality and cost for the full range of end-of-life care (Recommendation 1). The report
5 urges professional societies and other organizations to establish, and payers and health care
6 systems to adopt, quality standards specifically relating to patient-clinician communication and
7 advance care planning, toward the goal of ensuring that all individuals have an opportunity to
8 participate in decisions about their care and receive services consistent with their values, goals, and
9 preferences (Recommendation 2). It further calls on the federal government to require public
10 reporting of quality measures, outcomes and costs, for all programs it funds or administers, and to
11 encourage all other payment and delivery systems to do so as well (Recommendation 4).

12
13 *Professional Education, Licensure and Credentialing*

14
15 *Dying in America* recommends that all clinicians who provide care for patients with advanced
16 serious illness should be competent in basic palliative care and that educational institutions and
17 professional societies provide opportunities for lifelong learning in this area (Recommendation 3).
18 Accrediting organizations, certifying bodies, health systems, and regulatory agencies should
19 include training in palliative care in licensure requirements for health care professionals who
20 provide care for patients nearing the end of life, and resources should be committed to increase the
21 number of available training positions for specialty-level training in palliative care.

22
23 *Interoperable Electronic Health Records*

24
25 *Dying in America* identifies the need for “coordinated, efficient, interoperable” transfer of
26 information among all providers and settings of care to support high quality, integrated,
27 comprehensive care (Recommendation 1). It further calls for electronic health records that
28 document advance care planning to improve communication across providers and settings over
29 time, including providing for documentation of designation of a surrogate; patient values, goals,
30 and preferences; the patient’s advance directive (when the patient has one); and medical orders for
31 life-sustaining treatment (Recommendation 4). The report also urges states to develop and
32 implement Physician Orders for Life-Sustaining Treatment (POLST) programs “in accordance with
33 nationally standardized requirements.”

34
35 *Public Education about End of Life and Advance Care Planning*

36
37 Finally, *Dying in America* urges civic leaders, government entities, health care professionals, and
38 other stakeholders to collaborate in developing and disseminating evidence-based information
39 about care and the end of life and advance care planning to counter misinformation and encourage
40 meaningful dialogue (Recommendation 5). The report calls on stakeholders to support research to
41 assess public perceptions and actions, developing and testing effective messaging tailored to target
42 audiences, and measuring progress and results.

43
44 **AMA POLICY**

45
46 AMA has extensive policy relevant to end-of-life care and to support the ultimate goals of the
47 *Dying in America* report in all of the domains noted above. (See Appendix B.)

48
49 The AMA *Code of Medical Ethics* has strong, well-established guidance that recognizes the
50 importance of engaging patients in advance care planning so that patients’ values, goals, and
51 preferences can inform care planning (Opinions 5.1, 5.2). The *Code* calls on physicians to respect

1 patients' decisions about care at the end of life, including decisions to forgo or withdraw life-
2 sustaining interventions (Opinions 5.3, 5.4). The *Code* encourages physicians to engage pediatric
3 patients (Opinion 2.2.1) and adult patients with compromised decision-making capacity to
4 participate in treatment decisions to the extent possible, and recognizes the important role that
5 surrogate decision makers play when patients lack decision-making capacity (Opinion 2.1.2). The
6 *Code* further provides for the use of sedation to unconsciousness as an intervention of last resort for
7 terminally ill patients when distressing symptoms are refractory to appropriate, symptom-specific
8 palliative care (Opinion 5.6).

9
10 Policies of the AMA House of Delegates similarly promote advance care planning and patient-
11 centered decision making at the end of life (H-85.956, H-85.957, H-140.845, H-140.966, H-
12 140.970, H-140.989, D-140.968). House policies also encourage palliative care and hospice for
13 patients nearing the end of life and support education across the professional lifespan in these areas
14 (H-70.915, H-85.955, H-295.875), as well as in areas of medical specialization in which end-of-life
15 decision making can play a central role, such as geriatrics (H-295.981, D-295.969).

16
17 In addition, the AMA has adopted policy calling for affordable, interoperative electronic medical
18 records and medical devices to promote more effective coordination of care (D-478.994, D-
19 478.995, D-478.996), as well as policy that addresses essential frameworks for physician
20 maintenance of licensure and maintenance of certification (H-275.917, H-275.924). However,
21 AMA policy opposes tying physician licensure to mandated, content-specific continuing medical
22 education (H-275.973, H-295.921, H-300.953).

23 24 AMA PROGRAMS & ACTIVITIES

25
26 In addition to extensive policy, the AMA is (or has been) involved in numerous activities and
27 programs designed to improve care at the end of life consistent with the broad recommendations of
28 *Dying in America*. For example, the AMA was instrumental in the development of Education in
29 Palliative and End-of-Life Care (EPEC), a program designed to educate practicing physicians from
30 all specialties in palliative care, which is now offered by Northwestern University Feinberg School
31 of Medicine ([EPEC](#)). Journals in the [JAMA Network](#) offer a variety of online CME modules in
32 palliative care and pain management and live educational events at AMA meetings in recent years
33 have addressed communicating with patients for advance care planning [1].

34
35 Through its participation in the Liaison Committee on Medical Education (LCME) and
36 Accreditation Committee for Graduate Medical Education (ACGME), the AMA works to promote
37 comprehensive education for physician trainees to ensure that they acquire the knowledge and
38 skills to provide high quality, patient-centered care for a diverse patient population [2, 3]. Through
39 the Physician Consortium for Performance Improvement ([PCPI](#)), the AMA has contributed to
40 efforts to define and measure quality in end of life care.

41
42 With the American Bar Association, the American Hospital Association, the American Academy
43 of Hospice and Palliative Medicine and numerous other medical specialty societies, the AMA
44 annually supports [National Health Decisions Day](#), an initiative to provide information and
45 resources on advance care planning for both patients and health care professionals.

46
47 The AMA has argued for legal recognition of patients' right to control decisions about their care at
48 the end of life, including the right to refuse unwanted life-sustaining treatment [4]. The AMA has
49 advocated for legislative support of advance care planning and advance directives. The AMA's
50 efforts were instrumental in the decision by the Centers for Medicare & Medicaid Services to

1 include payment for AMA-developed CPT codes for advance care planning services in the [2016](#)
2 [Medicare Physician Fee Schedule \(PFS\) Final Rule](#).

3
4 The AMA's innovative STEPS Forward program of interactive, online educational modules
5 recently launched a new module, [Planning for End-of-Life Decisions with Your Patients](#), to help
6 physicians help patients convey their wishes about end of life care. The AMA is also a strong
7 advocate for improving the usability of electronic health records, and is collaborating with key
8 stakeholders in digital health to this end ([Digital Health](#)).

9
10 RECOMMENDATION

11
12 The Board of Trustees recommends that the following be adopted in lieu of Resolution 6-I-15 and
13 the remainder of this report be filed:

14
15 That our AMA reaffirm the following policies, which collectively promote high-quality,
16 patient-centered care for all patients at the end of life:

- 17
18 • H-70.915, Good Palliative Care
19 • H-85.955, Hospice Care
20 • H-85.956, Educating Physicians About Advance Care Planning
21 • H-85.957, Encouraging Standardized Advance Directive Forms within States
22 • H-140.845, Encouraging the Use of Advance Directives and Health Care Powers of
23 Attorney
24 • H-140.966, Decisions Near the End of Life
25 • H-140.970, Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients
26 • H-140.989, Informed Consent and Decision-Making in Health Care
27 • H-275.917, Licensure by Specialty
28 • H-275.924, Maintenance of Certification
29 • H-295.875, Palliative Care and End-of-Life Care
30 • H-295.981, Geriatric Medicine
31 • H-480.953, Interoperability of Medical Devices
32 • D-140.968, Standardized Advanced Directives
33 • D-295.969, Geriatric and Palliative Training for Physicians
34 • D-478.994, Health Information Technology
35 • D-478.995, National Health Information Technology
36 • D-478.996, Information Technology Standards and Costs

37
38 (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

1. Council on Ethical and Judicial Affairs. [*Resources in Advance Care Planning*](#). November 2010.
2. Liaison Committee on Medical Education. [*Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree*](#). March 2016.
3. Accreditation Committee for Graduate Medical Education. [*Requirements for Graduate Medical Education in Hospice and Palliative Medicine*](#). February 2015.
4. Brief for the Am. Med. Ass'n et al. as Amici Curiae Supporting Petitioner, *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990) (No. 88-1503).

APPENDIX A¹

Recommendations of the Institute of Medicine

Recommendation 1. Government health insurers and care delivery programs as well as private health insurers should cover the provision of comprehensive care for individuals with advanced serious illness who are nearing the end of life.

Comprehensive care should

- be seamless, high-quality, integrated, patient-centered, family-oriented, and consistently accessible around the clock;
- consider the evolving physical, emotional, social, and spiritual needs of individuals approaching the end of life, as well as those of their family and/or caregivers;
- be competently delivered by professionals with appropriate expertise and training;
- include coordinated, efficient, and interoperable information transfer across all providers and all settings; and
- be consistent with individuals' values, goals, and informed preferences.

Health care delivery organizations should take the following steps to provide comprehensive care:

- All people with advanced serious illness should have access to skilled palliative care or, when appropriate, hospice care in all settings where they receive care (including health care facilities, the home, and the community).
- Palliative care should encompass access to an interdisciplinary palliative care team, including board-certified hospice and palliative medicine physicians, nurses, social workers, and chaplains, together with other health professionals as needed (including geriatricians). Depending on local resources, access to this team may be on site, via virtual consultation, or by transfer to a setting with these resources and this expertise.
- The full range of care that is delivered should be characterized by transparency and accountability through public reporting of aggregate quality and cost measures for all aspects of the health care system related to end-of-life care. The committee believes that informed individual choices should be honored, including the right to decline medical or social services.

Recommendation 2. Professional societies and other organizations that establish quality standards should develop standards for clinician-patient communication and advance care planning that are measurable, actionable, and evidence-based. These standards should change as needed to reflect the evolving population and health system needs and be consistent with emerging evidence, methods, and technologies. Payers and health care delivery organizations should adopt these standards and their supporting processes, and integrate them into assessments, care plans, and the reporting of health care quality. Payers should tie such standards to reimbursement, and professional societies should adopt policies that facilitate tying the standards to reimbursement, licensing, and credentialing to encourage

- all individuals, including children with the capacity to do so, to have the opportunity to participate actively in their health care decision making throughout their lives and as they approach death, and receive medical and related social services consistent with their values, goals, and informed preferences;

¹ Institute of Medicine. *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*. Washington, DC: National Academies Press; 2015.

- clinicians to initiate high-quality conversations about advance care planning, integrate the results of these conversations into the ongoing care plans of patients, and communicate with other clinicians as requested by the patient; and
- clinicians to continue to revisit advance care planning discussions with their patients because individuals' preferences and circumstances may change over time.

Recommendation 3. Educational institutions, credentialing bodies, accrediting boards, state regulatory agencies, and health care delivery organizations should establish the appropriate training, certification, and/or licensure requirements to strengthen the palliative care knowledge and skills of all clinicians who care for individuals with advanced serious illness who are nearing the end of life.

Specifically,

- all clinicians across disciplines and specialties who care for people with advanced serious illness should be competent in basic palliative care, including communication skills, interprofessional collaboration, and symptom management;
- educational institutions and professional societies should provide training in palliative care domains throughout the professional's career;
- accrediting organizations, such as the Accreditation Council for Graduate Medical Education, should require palliative care education and clinical experience in programs for all specialties responsible
- for managing advanced serious illness (including primary care clinicians);
- certifying bodies, such as the medical, nursing, and social work specialty boards, and health systems should require knowledge, skills, and competency in palliative care; state regulatory agencies should include education and training in palliative care in licensure requirements for physicians, nurses, chaplains, social workers, and others who provide health care to those nearing the end of life;
- entities that certify specialty-level health care providers should create pathways to certification that increase the number of health care professionals who pursue specialty-level palliative care training; and
- entities such as health care delivery organizations, academic medical centers, and teaching hospitals that sponsor specialty-level training positions should commit institutional resources to increasing the number of available training positions for specialty-level palliative care.

Recommendation 4. Federal, state, and private insurance and health care delivery programs should integrate the financing of medical and social services to support the provision of quality care consistent with the values, goals, and informed preferences of people with advanced serious illness nearing the end of life. To the extent that additional legislation is necessary to implement this recommendation, the administration should seek and Congress should enact such legislation. In addition, the federal government should require public reporting on quality measures, outcomes, and costs regarding care near the end of life (e.g., in the last year of life) for programs it funds or administers (e.g., Medicare, Medicaid, the U.S. Department of Veterans Affairs). The federal government should encourage all other payment and health care delivery systems to do the same.

Specifically, actions should

- provide financial incentives for
 - medical and social support services that decrease the need for emergency room and acute care services,

- coordination of care across settings and providers (from hospital to ambulatory settings as well as home and community), and
- improved shared decision making and advance care planning that reduces the utilization of unnecessary medical services and those not consistent with a patient's goals for care;
- require the use of interoperable electronic health records that incorporate advance care planning to improve communication of individuals' wishes across time, settings, and providers, documenting (1) the designation of a surrogate/decision maker, (2) patient values and beliefs and goals for care, (3) the presence of an advance directive, and (4) the presence of medical orders for life-sustaining treatment for appropriate populations; and
- encourage states to develop and implement a Physician Orders for Life-Sustaining Treatment (POLST) paradigm program in accordance with nationally standardized core requirements.

Medical and social services provided should accord with a person's values, goals, informed preferences, condition, circumstances, and needs, with the expectation that individual service needs and intensity will change over time. High-quality, comprehensive, person-centered, and family-oriented care will help reduce preventable crises that lead to repeated use of 911 calls, emergency department visits, and hospital admissions, and if implemented appropriately, should contribute to stabilizing aggregate societal expenditures for medical and related social services and potentially lowering them over time.

Recommendation 5. Civic leaders, public health and other governmental agencies, community-based organizations, faith-based organizations, consumer groups, health care delivery organizations, payers, employers, and professional societies should engage their constituents and provide fact-based information about care of people with advanced serious illness to encourage advance care planning and informed choice based on the needs and values of individuals.

Specifically, these organizations and groups should

- use appropriate media and other channels to reach their audiences, including underserved populations;
- provide evidence-based information about care options and informed decision making regarding treatment and care;
- encourage meaningful dialogue among individuals and their families and caregivers, clergy, and clinicians about values, care goals, and preferences related to advanced serious illness; and
- dispel misinformation that may impede informed decision making and public support for health system and policy reform regarding care near the end of life.

In addition,

- health care delivery organizations should provide information and materials about care near the end of life as part of their practices to facilitate clinicians' ongoing dialogue with patients, families, and caregivers;
- government agencies and payers should undertake, support, and share communication and behavioral research aimed at assessing public perceptions and actions with respect to end-of-life care, developing and testing effective messages and tailoring them to appropriate audience segments, and measuring progress and results; and
- health care professional societies should prepare educational materials and encourage their members to engage patients and their caregivers and families in advance care planning, including end-of-life discussions and decisions.

All of the above groups should work collaboratively, sharing successful strategies and promising practices across organizations.

APPENDIX B

AMA Policies Relating to End-of-Life and Palliative Care

Policy	Issued
<i>Advance Care Planning</i>	
E-2.191 Advance Care Planning	2011
E-2.225 Optimal Use of Orders-Not-to-Intervene and Advance Directives	1998
D-140.968 Standardized Advanced Directives	2007 ¹
H-85.957 Encouraging Standardized Advance Directive Forms within States	2011
H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney	2014 ²
H-330.891 Payment and Coverage for Voluntary Discussions of End-of-Life Issues	2011
<i>Decisions Regarding Life-Sustaining Treatment</i>	
E-2.20 Withholding or Withdrawing Life-Sustaining Medical Treatment	1984 ³
E-2.201 Sedation to Unconsciousness in End-of-Life Care	2008
E-2.22 Do-Not-Resuscitate Orders	1992 ⁴
E-8.081 Surrogate Decision Making	2001
E-10.016 Pediatric Decision Making	2008 ⁵
H-140.966 Decisions Near the End of Life	1991 ⁶
H-140.970 Decisions to Forgo Life-Sustaining Treatment for Incompetent Patients	1991 ⁷
H-280.968 Do Not Hospitalize Orders	1993 ⁸
<i>Symptom Management, Palliative Care & Hospice</i>	
H-55.999 Symptomatic and Supportive Care for Patients with Cancer	1978 ⁹
H-70.915 Good Palliative Care	2014
H-85.955 Hospice Care	2014
H-85.966 Hospice Coverage and Underutilization	1994 ¹⁰
H-165.834 National Pain Care	2010
H-295.875 Palliative Care and End-of-Life Care	2006 ¹¹
<i>Physician Education</i>	
D-295.969 Geriatric and Palliative Training for Physicians	2002 ¹²
H-85.956 Educating Physicians About Advance Care Planning	2014
H-295.981 Geriatric Medicine	1985 ¹³
H-295.995 Recommendations for Future Directions for Medical Education	1982 ¹⁴
<i>Physician Licensure & Certification</i>	
H-275.997 Licensure by Specialty	1980 ¹⁵
H-275.917 An Updated on Maintenance of Licensure	2015
H-275.924 Maintenance of Certification	2009 ¹⁶
<i>Health Information Technologies</i>	
D-478.994 Health Information Technology	2005 ¹⁷
D-478.995 National Health Information Technology	2004 ¹⁸
D-478.996 Information Technology Standards and Costs	2004 ¹⁹
H-480.953 Interoperability of Medical Devices	2009 ²⁰
<i>Quality Measures</i>	
H-450.958 Support for Development of Measures of Quality	1997 ²¹
H-450.966 Quality Management	1994 ²²

- ¹ Reaffirmed 2015
- ² Reaffirmed 2015
- ³ Updated 1996
- ⁴ Updated 2005
- ⁵ Updated 2010
- ⁶ Reaffirmed 2013
- ⁷ Reaffirmed 2009
- ⁸ Reaffirmed 2010
- ⁹ Updated 2010
- ¹⁰ Updated 2014
- ¹¹ Amended, Res 322 A-14
- ¹² Reaffirmed 2012
- ¹³ Amended, Res 301 A-10
- ¹⁴ Reaffirmed 2011
- ¹⁵ Reaffirmed 2010
- ¹⁶ Updated 2015
- ¹⁷ Reaffirmed 2014
- ¹⁸ Reaffirmed 2015
- ¹⁹ Reaffirmed 2014
- ²⁰ Reaffirmed 2015
- ²¹ Reaffirmed 2007
- ²² Reaffirmed 2015

REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-I-16

Subject: Designation of Specialty Societies for Representation in the House of Delegates

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 At the American Medical Association’s (AMA) 2007 Annual Meeting, Policy G-600.135 (see
2 Appendix A for policies cited in report) was adopted, establishing a mechanism by which specialty
3 society representation in the House of Delegates (HOD) would be determined. The mechanism for
4 specialty society delegate allocation is based on a formula that looks at a society’s AMA
5 membership and the number of ballots cast for representation in each specialty (Appendix B). The
6 specialty ballot is available online at www.ama-assn.org/go/ballot. The goal was to determine
7 appropriate allocation of specialty society delegates. However, this system does not work as it
8 relies on members making an active selection of a specialty society to represent them, and despite
9 efforts by both our AMA and the specialty societies, few members make a choice, likely because
10 the value of doing so is not well understood by the average member.

11
12 Since 2007, there have been a number of reports put forth attempting to improve the specialty
13 delegate allocation process (Policies included in Appendix A). Previous reports have all attempted
14 to present solutions to the challenge of fair allocation of specialty society delegates. The most
15 recent report was at the 2016 Annual Meeting and as with previous reports, was referred back for
16 further development. From the debate at A-16 two critical issues have been identified; the HOD
17 wants parity in representation; and there is a desire for a simple method of allocation that is applied
18 to both the constituent associations and the specialty societies. (AMA Bylaws define constituent
19 associations as recognized medical associations of states, commonwealths, districts, or territories of
20 the United States.)

21
22 This report seeks to address these issues and offer a solution. The Board of Trustees (BOT), with
23 input from the Specialty and Service Society (SSS), believes that the following is a reasonable and
24 equitable solution.

25
26 In order to establish parity the number of constituent delegates and specialty delegates should be
27 equal. Under the theory that every AMA member should be represented by both a constituent
28 association and a specialty society in the HOD—the stated goal since 1996—the number of
29 constituent and specialty delegates should be equal. The total AMA membership figure that
30 determines the number of constituent delegates should also be used to determine the number of
31 specialty delegates.

32
33 Constituent delegate allocation will continue to be based on the address for each AMA member,
34 without respect to constituent society membership. Specialty delegate allocation is slightly more
35 challenging because while one can only reside in one state, a member may belong to more than one
36 specialty society.

1 Specialty society delegate allocation should be determined using data that is submitted by each
2 specialty society every five years to determine their eligibility to remain in the HOD. While the
3 membership numbers may fluctuate over five years, this will be the most reliable mark of AMA
4 membership for each specialty.

5
6 Under AMA bylaws delegates are apportioned for the coming year each January, after the prior
7 year's membership figures have been finalized. Current policy allows for one AMA delegate for
8 every 1,000 AMA members or fraction thereof an organization has. The same standard should
9 apply to both the constituent association and specialty society delegate allocation.

10
11 Once the total number of constituent society delegates allocated for any given year is determined
12 then specialty society delegates would be adjusted up or down so that the total number of specialty
13 society delegates equals the number of constituent society delegates. If the total number of
14 allocated specialty society delegates is fewer than the total number of delegates allocated to
15 constituent societies, additional delegates would be apportioned, one each, to those specialty
16 societies that are numerically closest to qualifying for an additional delegate, until the total number
17 of national specialty society delegates equals the number of constituent society delegates.
18 Conversely, should the total number of allocated specialty society delegates be greater than the
19 number of delegates allocated to constituent societies, then the excess delegates will be removed,
20 one each, from those societies numerically closest to losing a delegate, until the total number of
21 national specialty society delegates equals the number of constituent society delegates. With the
22 adjustment, a few specialty societies will not truly have a 1 to 1,000 or fraction thereof ratio, but no
23 specialty would gain or lose more than one delegate. This method would allow for the adjustment
24 of delegation sizes to achieve parity between constituent society and specialty society
25 representation while still using membership data as the guide.

26
27 Organizations with fewer than 1,000 AMA members would remain at one delegate as long as they
28 retain representation in the HOD. Delegate allocation would continue to be adjusted annually based
29 on AMA membership data, and specialty delegates would move annually in concert with the
30 number of state delegates. In addition, as new specialty societies enter or leave the HOD, the
31 delegate allocation of all specialties would be adjusted.

32
33 The attached chart (Appendix C) shows the impact implementation of this system would have had
34 in 2016; the membership numbers on the chart are the latest available membership numbers, some
35 of which were collected in preparing BOT Report 15-A-16.

36 37 RECOMMENDATION

38
39 The Board of Trustees recommends that the following recommendations be adopted and the
40 remainder of the report be filed:

- 41
42 1. That the current specialty society delegation allocation system (using a formula that
43 incorporates the ballot) be discontinued; and that specialty society delegate allocation in the
44 House of Delegates be determined so that the total number of national specialty society
45 delegates shall be equal to the total number of delegates apportioned to constituent societies
46 under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on
47 the latest available membership data for each society, which is generally from the society's
48 most recent five year review. (Directive to Take Action)
- 49
50 2. That specialty society delegate allocation be determined annually, based on the latest available
51 membership data, using a two-step process:

- 1 a) First, the number of delegates per specialty society will be calculated as one delegate per
2 1,000 AMA members in that society, or fraction thereof.
3
- 4 b) Second, the total number of specialty society delegates will be adjusted up or down to
5 equal the number of delegates allocated to constituent societies.
6
- 7 i) Should the calculated total number of specialty society delegates be fewer than the
8 total number of delegates allocated to constituent societies, additional delegates will be
9 apportioned, one each, to those societies that are numerically closest to qualifying for
10 an additional delegate, until the total number of national specialty society delegates
11 equals the number of constituent society delegates.
12
- 13 ii) Should the calculated total number of specialty society delegates be greater than the
14 number of delegates allocated to constituent societies, then the excess delegates will be
15 removed, one each, from those societies numerically closest to losing a delegate, until
16 the total number of national specialty society delegates equals the number of
17 constituent society delegates. (Directive to Take Action)
18
- 19 3. That the Council on Constitution and Bylaws investigate the need to change any policy or
20 bylaws needed to implement a new system to apportion national medical specialty society
21 delegates. (Directive to Take Action)
22
- 23 4. That this new specialty society delegate apportionment process be implemented at the first
24 Annual Meeting of the House of Delegates following the necessary bylaws revisions.
25 (Directive to Take Action)

Fiscal Note: Less than \$500 to implement.

Appendix A – Bylaws and Policy

Retention of Delegate, B-2.1.1.1.1

If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.

G-600.021 Specialty Society Representation in our AMA House

The number of AMA delegate positions allocated to the specialty societies in our AMA/Federation House will be determined in the following manner: (1) The number of delegates and alternate delegates allocated to a specialty society will be on the basis of one delegate and one alternate delegate for each 1,000 AMA members, or portion of 1,000 AMA members, who select that a particular specialty society on the annual ballot and return the ballot to our AMA; and (2) Each specialty society that meets the eligibility criteria and is represented in our AMA/Federation House will be assured of at least one delegate and alternate delegate position regardless of the number of AMA members who select the society on the ballot and return the ballot to the AMA. (3) Our AMA will: (a) continue to include the ballot postcard in the Member Welcome Kit; (b) continue to promote the online ballot application to increase specialty society designations; (c) work with all willing specialty societies to solicit additional specialty society designations, using both printed ballots and electronic communications vehicles; and (d) continue to send email ballot solicitations to members who have not yet cast a ballot. (4) The current ballot system will remain in place while the Speakers, working with the Specialty and Service Society, examine other options for ensuring that each member of the American Medical Association is adequately represented by both a state medical association and national medical specialty society.

G-600.023 Designation of Specialty Societies for Representation in the House of Delegates

1. Specialty society delegate allocation in the House of Delegates shall be determined in the same manner as state medical society delegate allocation based on membership numbers allowing one delegate per 1,000 AMA members or fraction thereof.
2. Specialty society membership data shall be submitted annually by all societies with more than one delegate or societies seeking to obtain an additional delegate or delegates as part of a two-year pilot program with a report back at the 2016 Annual Meeting of our AMA House of Delegates.
3. The current specialty delegation allocation system (ballot and formula) will be continued until the pilot program is completed and the 2016 Annual Meeting report is acted upon by the House of Delegates.
4. This system shall be tested with all specialty societies with more than one delegate seated in the House of Delegates.
5. Organizations that would lose or gain one or more delegates through this pilot delegate allocation system shall assist our AMA with documenting the impact. However, no actual changes to delegation allocation other than those which occur through the five-year review and balloting system will be implemented until the data are collected and presented for acceptance to our AMA House of Delegates at the 2016 Annual Meeting.
6. In the future, any system of delegate allocation will continue to be monitored and evaluated for improvements.

G-600.135 Specialty Society Delegate Representation in the House of Delegates

1. Our AMA will continue efforts to expand awareness and use of the designation mechanism for specialty society representation, working wherever possible with relevant members of the Federation. 2. The system of apportioning delegates to specialty societies be enhanced by a systematic allocation of delegates to specialty societies by extrapolating from the current process in which members designate a specialty society for representation. The recommended model will: (a) establish annual targets for the overall proportion of AMA members from whom designations should have been received; (b) adjust actual designations by increasing them proportionately to achieve the overall target level of designations; (c) limit the number of delegates a society can acquire to the number that would be obtained if all the society's AMA members designated it for representation; (d) be initiated with delegate allocations for 2008, following the expiration of the freeze, which ends December 31, 2007; and (e) be implemented over five years because this will result in the least disruption to the House of Delegates and allow the process to unfold naturally. 3. The Board of Trustees will prepare annual reports to the House describing efforts undertaken to solicit designations from members, characterizing progress in collecting designations, and recommending changes in strategies that might be required to implement existing policy on representation of specialty societies. In addition, the Board should, in these or other reports: (a) develop a system for use among direct members to solicit their designations of specialty societies for representation, with an eye on how that system might be expanded or adapted for use among other members; and (b) engage in discussions with specialty societies that will lead to enhanced data sharing so that delegate allocations for both state and specialty societies can be handled in parallel fashion. 4. Our AMA will include in the specialty designation system an option to permit those members who wish to opt out of representation by a specialty society to do so when any automatic allocation system is used to provide representation for specialty societies that are represented in the House of Delegates. 5. If any specialty society loses delegates as a result of the apportionment process, the specialty society shall have a one-year grace period commencing January 1, 2008. At the expiration of this one-year grace period, a phase-in period shall be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented. 6. AMA Bylaw 2.11111 grants state societies a one-year grace period following the freeze expiring December 31, 2007 (per Bylaw 2.121). At the end of the grace period, a phase-in period will be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented.

Appendix B – 2016 Apportionment of Specialty Society Delegates

Board of Trustees Report 17-A-07 implemented the current mechanism for apportioning delegates to specialty societies in the House of Delegates.

The starting point for societies is the number of ballots submitted by AMA members designating a particular specialty society to represent their interests in the House of Delegates. That number is weighted, using the formula developed in BOT Report 17-A-07, and the resulting figure apportions delegates at the rate of one per 1,000 or fraction thereof, subject to a cap based on the number of AMA members in the society.

The weighting factor is directly related to the total AMA membership and inversely related to the proportion of AMA members who have actually designated a society for representation purposes. That is, as AMA membership increases, the weight increases, and as the proportion of members casting a ballot increases, the weight decreases. The weight is limited to 80% of its calculated value, and the same weight applies to every specialty society.

Elements of the formula are (with their 2016 values):

- a. Members eligible to ballot, 4th year student or beyond (198,408)
- b. Actual ballots (54,571, which includes 447 who chose NOT to designate a specialty society)
- c. a/b ($54,971/198,408 = 0.27504$)
- d. $1/c$ ($1 / 0.27504 = 3.635777$)
- e. $d * 0.8$ ($3.635777 * 0.8 = 2.908622$)
- f. $e * \text{ballots} / 1000$, with result rounded up to next whole number

The delegate apportionment is subject to the following constraints:

1. Every specialty society seated in the House of Delegates has at least one delegate;
2. The number of delegates cannot exceed the figure that would apply if ALL its AMA members selected that society for representation purposes.

The following example illustrates use of the formula. If at year end 2015 a society had 1,015 ballots and 7,913 AMA members:

$1015 * 2.909 / 1000 \rightarrow 2952.6 / 1000 \rightarrow 2.9 \rightarrow$ rounds up to 3; but if all 7913 AMA members had designated the society, the cap would be 8 delegates ($7913 / 1000 = 7.9 \rightarrow$ rounds up to 8). The society gets the lesser of the calculated number or the cap, or in this case 3 delegates.

Appendix C

The 2016 delegate allocation for the constituent medical societies was 265 delegates. Applying the system outlined in this report would have resulted in the delegate allocation shown in the column labeled adjusted delegate allocation for the specialties.

	AMA Membership	Actual 2016 Delegates	1 per 1,000 or Fraction Thereof	Rounding Factor	Adjustment	Adjusted Delegate Allocation
Academy of Physicians in Clinical Research	148	1	1			1
Aerospace Medical Association	173	1	1			1
AMDA - The Society for Post-Acute and Long Term Care Medicine	873	1	1			1
American Academy of Allergy, Asthma and Immunology	361	1	1			1
American Academy of Child and Adolescent Psychiatry	1,446	1	2	446		2
American Academy of Cosmetic Surgery	348	1	1			1
American Academy of Dermatology	2,955	4	3	955		3
American Academy of Facial Plastic and Reconstructive Surgery	365	1	1			1
American Academy of Family Physicians	17,323	18	18	323		18
American Academy of Hospice and Palliative Medicine	700	1	1			1
American Academy of Insurance Medicine	64	1	1			1
American Academy of Neurology	2,207	3	3	207		3
American Academy of Ophthalmology	3,380	4	4	380		4
American Academy of Orthopaedic Surgeons	6,755	5	7	755		7
American Academy of Otolaryngic Allergy Inc.	386	1	1			1
American Academy of Otolaryngology-Head and Neck Surgery	2,895	3	3	895		3
American Academy of Pain Medicine	471	1	1			1
American Academy of Pediatrics	8,160	7	9	160		9

	AMA Membership	Actual 2016 Delegates	1 per 1,000 or Fraction Thereof	Rounding Factor	Adjustment	Adjusted Delegate Allocation
American Academy of Physical Medicine and Rehabilitation	1,838	2	2	838		2
American Academy of Psychiatry and the Law	359	1	1			1
American Academy of Sleep Medicine	1,236	1	2	236		2
American Association for Geriatric Psychiatry	876	1	1			1
American Association for Hand Surgery	266	1	1			1
American Association for Thoracic Surgery	279	1	1			1
American Association of Clinical Endocrinologists	815	1	1			1
American Association of Clinical Urologists,	968	1	1			1
American Association of Gynecologic Laparoscopists	1,264	1	2	264		2
American Association of Hip and Knee Surgeons	381	1	1			1
American Association of Neurological Surgeons	902	2	1			1
American Association of Neuromuscular & Electrodiagnostic Medicine	809	1	1			1
American Association of Plastic Surgeons	175	1	1			1
American Association of Public Health Physicians	45	1	1			1
American Clinical Neurophysiology Society	197	1	1			1
American College of Allergy, Asthma and Immunology	555	1	1			1
American College of Cardiology	5,693	4	6	693		6
American College of Chest Physicians	2,552	1	3	552		3
American College of Emergency Physicians	6,705	5	7	705		7
American College of Gastroenterology	1,383	2	2	383		2
American College of Legal Medicine	133	1	1			1

	AMA Membership	Actual 2016 Delegates	1 per 1,000 or Fraction Thereof	Rounding Factor	Adjustment	Adjusted Delegate Allocation
American College of Medical Genetics and Genomics	356	1	1			1
American College of Medical Quality	134	1	1			1
American College of Mohs Surgery	219	1	1			1
American College of Nuclear Medicine	81	1	1			1
American College of Occupational and Environmental Medicine	547	1	1			1
American College of Phlebology	310	1	1			1
American College of Physicians	22,690	13	23	690		23
American College of Preventive Medicine	484	1	1			1
American College of Radiation Oncology	323	1	1			1
American College of Radiology	6,077	7	7	77	-1	6
American College of Rheumatology	1,095	2	2	95	-1	1
American College of Surgeons	12,445	6	13	445		13
American Congress of Obstetricians and Gynecologists	12,000	12	12			12
American Gastroenterological Association	1,709	1	2	709		2
American Geriatrics Society	927	1	1			1
American Institute of Ultrasound in Medicine	1,216	1	2	216		2
American Medical Group Association	2,928	1	3	928		3
American Orthopaedic Association	311	1	1			1
American Orthopaedic Foot and Ankle Society	262	1	1			1
American Psychiatric Association	7,478	8	8	478		8
American Roentgen Ray Society	2,377	1	3	377		3

	AMA Membership	Actual 2016 Delegates	1 per 1,000 or Fraction Thereof	Rounding Factor	Adjustment	Adjusted Delegate Allocation
American Society for Aesthetic Plastic Surgery, Inc.	348	1	1			1
American Society for Clinical Pathology	2,127	1	3	127		3
American Society for Dermatologic Surgery	1,016	1	2	16	-1	1
American Society for Gastrointestinal Endoscopy	1,662	1	2			2
American Society for Radiation Oncology	839	1	1			1
American Society for Reproductive Medicine	794	1	1			1
American Society for Surgery of the Hand	666	1	1			1
American Society of Addiction Medicine	623	1	1			1
American Society of Anesthesiologists	6,146	7	7	146		7
American Society of Breast Surgeons	568	1	1			1
American Society of Cataract and Refractive Surgery	1,133	1	2	133		2
American Society of Clinical Oncology	3,227	2	4	227		4
American Society of Colon and Rectal Surgeons	228	1	1			1
American Society of Cytopathology	214	1	1			1
American Society of Dermatopathology	344	0	1			1
American Society of Echocardiography	1,135	1	2	135		2
American Society of General Surgeons	341	1	1			1
American Society of Hematology	861	1	0			0
American Society of Interventional Pain Physicians	544	1	1			1
American Society of Maxillofacial Surgeons	82	1	1			1
American Society of Metabolic and Bariatric Surgery	313	1	1			1

	AMA Membership	Actual 2016 Delegates	1 per 1,000 or Fraction Thereof	Rounding Factor	Adjustment	Adjusted Delegate Allocation
American Society of Neuroimaging	90	1	1			1
American Society of Neuroradiology	478	1	1			1
American Society of Ophthalmic Plastic and Reconstructive Surgery	160	1	1			1
American Society of Plastic Surgeons	919	2	1			1
American Society of Retina Specialists	608	1	1			1
American Thoracic Society	1,307	1	2	307		2
American Urological Association	1,181	2	2	181		2
Association of Military Surgeons of the United States	687	1	1			1
Association of University Radiologists	181	1	1			1
College of American Pathologists	3,294	4	4	294		4
Congress of Neurological Surgeons	983	1	1			1
Contact Lens Association of Ophthalmologists, Inc.	37	1	1			1
The Endocrine Society	1,086	1	2	86	-1	1
Heart Rhythm Society	651	1	1			1
Infectious Diseases Society of America	1,147	1	2	147		2
International Academy of Independent Medical Evaluators	191	1	1			1
International College of Surgeons - US Section	313	1	1			1
International Society for the Advancement of Spine Surgery	134	1	1			1
International Society for Hair Restoration Surgery	91	1	0			0
National Association of Medical Examiners	169	1	1			1
North American Spine Society	1,345	1	2	345		2
Obesity Medical Association	259	1	1			1

B of T Rep. 6-I-16 -- 12 of 12

	AMA Membership	Actual 2016 Delegates	1 per 1,000 or Fraction Thereof	Rounding Factor	Adjustment	Adjusted Delegate Allocation
Radiological Society of North America	2,446	1	3			3
Renal Physicians Association	586	1	1			1
Spine Intervention Society	542	1	1			1
Society for Cardiovascular Angiography and Interventions	434	1	1			1
Society for Investigative Dermatology, Inc.	207	1	1			1
Society for Vascular Surgery	762	1	1			1
Society of American Gastrointestinal Endoscopic Surgeons	1,131	1	2	131		2
Society of Critical Care Medicine	911	1	1			1
Society of Hospital Medicine	1,556	1	2	556		2
Society of Interventional Radiology	580	1	1			1
Society of Laproendoscopic Surgeons	982	1	1			1
Society of Nuclear Medicine and Molecular Imaging	505	1	1			1
Society of Thoracic Surgeons	1,192	2	2	192		2
The Triological Society	152	1	1			1
Undersea and Hyperbaric Medical Society	186	1	1			1
United States and Canadian Academy of Pathology, Inc.	1,281	1	2	281		2
Total delegates		220	269		-4	265

REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-I-16

Subject: Supporting Autonomy for Patients with Differences of Sex Development (DSD)
(Resolution 3-A-16)

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 At the 2016 Annual Meeting, the American Medical Association (AMA) House of Delegates
2 referred to the Board of Trustees Resolution 3-A-16, “Supporting Autonomy for Patients with
3 Differences of Sex Development (DSD),” introduced by the Medical Student Section. Resolution 3
4 asked:

5
6 That our AMA affirm that medically unnecessary surgeries in individuals born with
7 differences of sex development are unethical and should be avoided until the patient
8 can actively participate in decision-making.
9

10 Testimony was largely in favor of referral. Those offering testimony understood the key
11 developmental issues surrounding individuals born with DSD. However, testimony revealed gaps
12 in understanding about how to address appropriately surgical and medical options in providing
13 care, necessitating a call for further study.
14

15 **BACKGROUND**

16
17 The term “differences of sex development” (DSD) refers to congenital conditions in which
18 development of chromosomal, gonadal, or anatomic sex is atypical [1]. The frequency of DSDs
19 varies with etiology [2], but overall incidence of DSD is estimated to be one in 5,500 births; some
20 60 percent of affected children are now diagnosed prenatally [3]. Diagnosis of DSD is complex,
21 encompassing family and prenatal history, physical examination (particularly of genital anatomy),
22 and various laboratory tests, including determination of chromosomal sex. Diagnosis may also
23 involve ultrasound or other imaging studies, hormonal stimulation tests (eg, human chorionic
24 gonadotropin or adrenocorticotropin stimulation), and, in rare cases, laparotomy or laparoscopy [3].
25 Not all cases of DSD are diagnosed perinatally.
26

27 DSD include potentially life-threatening developmental anomalies that may require immediate
28 intervention, for example, hypotension resulting from salt-wasting nephropathy, which occurs in 75
29 percent of infants born with congenital adrenal hyperplasia. DSD also includes “cosmetic”
30 abnormalities for which elective interventions to normalize appearance can be undertaken at
31 various stages in the child’s life [2,4].
32

33 Historically, assigning gender in a newborn with ambiguous genitalia has been viewed as a
34 “medical emergency,” with immediate surgery recommended to match genitalia to the assigned
35 gender, on the rationale that uncertain gender is distressing for the family, may adversely affect the
36 child’s mental health, and can lead to stigmatization [3,5]. This view has been increasingly

1 challenged [2,4,6]. DSD communities and a growing number of health care professionals have
2 condemned such genital “normalizing,” arguing that except in the rare cases in which DSD
3 presents as life-threatening anomalies, genital modification should be postponed until the patient
4 can meaningfully participate in decision making [4,7,8].

5
6 In 2006, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) observed
7 the lack of sufficient data to guide decisions about gender assignment and absence of clear
8 guidelines for clinical practice [9]. The NIDDK also noted that there are only limited long-term
9 outcome data on early surgical reconstruction, despite concern about irreversibility and possible
10 sensory damage to the genitalia. Finally, the NIDDK cited a lack of “systematic outcome data
11 about sexual function in individuals with disorders of sexual differentiation [sic]” and of data
12 “pertaining to the association of sexual function with genital appearance and types of genital
13 surgery.” It therefore called for prospective studies of gender identity, reproductive function, and
14 quality of life for patients with DSD “to guide clinicians and families in making decisions about
15 gender assignment and surgical reconstruction.”

16
17 Also in 2006, the Intersex Society of North America (ISNA) released its “Clinical Guidelines for
18 the Management of Disorders of Sex Development in Childhood,” gathering perspectives of
19 treating physicians, past patients, and parents who have been involved in the management of DSD
20 [1]. The guidelines address appropriate treatment options for common genital anomalies, focusing
21 on patient- and family-centered care provided by a well-trained multidisciplinary team. The
22 guidelines acknowledge that each patient requires unique attention and resources. Importantly,
23 ISNA guidelines note that gender assignment “is a social and legal process *not requiring medical*
24 *or surgical intervention*” (original emphasis) [1].

25
26 A small study carried out in 2011-2012 among medical students in Zurich found that how
27 physicians discussed treatment for a child with DSD influenced the choice for or against surgery,
28 despite respondents’ belief that their personal attitudes governed decision making [10]. Participants
29 watched brief counseling videos that offered either a “medicalized” or “demedicalized” approach.
30 That is, the video described DSD as a condition that is static, has an inherent psychosocial
31 component, and requires treatment, and for which predetermined treatment regimens focus on
32 biological function, or as a dynamic disorder characterized by context-dependent impairment for
33 which coping strategies should be fostered, with treatment geared to the individual’s interests and
34 capabilities. Sixty-six percent of participants who viewed the medicalized video said they would
35 choose early surgery for their child, compared to 23 percent of those who viewed the
36 demedicalized video.

37 38 CURRENT AMA POLICY

39
40 Current AMA policy does not address treatment for patients with DSD directly. Rather, a limited
41 number of ethics and House policies speak to decisions for minors more broadly, as well as to
42 issues pertaining to gender identity, sexual orientation, transgender health, and discrimination
43 toward sexual minority communities:

- 44
- 45 • [Opinion 2.2.1](#), “Pediatric Decision Making,” encourages involving minor patients in decision
46 making at a developmentally appropriate level, including decisions that involve life-sustaining
47 interventions, and recommends that clinicians work with parents or guardians to simplify
48 complex treatment regimens for children with chronic health conditions.
 - 49 • [Opinion 2.2.4](#), “Treatment Decisions for Seriously Ill Newborns,” articulates the considerations
50 that must be taken into account when addressing emotionally and ethically challenging cases
51 involving newborns, including: the medical needs of the child; the interests, needs, and

1 resources of the family; available treatment options; and respect for the child’s right to an
2 “open future.” It calls on physicians to inform parents about available therapeutic options and
3 the nature of those options and to discuss the child’s expected prognosis with and without
4 intervention.

- 5 • [Opinion 2.2.5](#), “Genetic Testing of Children,” identifies conditions under which physicians
6 may ethically offer genetic testing for minor patients. It observes that testing implicates
7 important concerns about the autonomy and best interests of the minor patient and holds that
8 medical decisions made on behalf of a child should not abrogate the opportunity to choose to
9 know his or her genetic status as an adult.
- 10 • [H-525.987](#), “Surgical Modification of Female Genitalia,” opposes medically unnecessary
11 surgical modification of female genitalia and encourages the development of educational
12 programs to address complications and corrective procedures.
- 13 • [H-475.992](#), “Definitions of ‘Cosmetic’ and ‘Reconstructive’ Surgery,” distinguishes cosmetic
14 surgery, performed on normal bodily structures to improve patient appearance, from
15 reconstructive surgery, performed on abnormal bodily structures to improve function or
16 approximate normal appearance.

17 18 DECISIONS FOR PEDIATRIC PATIENTS

19
20 Parents (or guardians) are granted the authority to make health care decisions for their minor
21 children when the child lacks the ability to act independently or does not have the capacity to make
22 medical decisions [11]. Parents are deemed to be in a better position than others to understand their
23 child’s unique needs and interests, as well as their families’, and thus to be able to make
24 appropriate decisions regarding their child’s health care. Historically, the best interest standard has
25 predominated as the appropriate decision-making standard for medical decisions for minors.
26 Current consensus rests on a more nuanced view that encompasses not only the patient’s medical
27 interests, but psychosocial and familial concerns as well [11].
28

29 The “harm principle” has been suggested as a further refinement on the decision-making standard,
30 requiring not only that decision makers consider the patient’s best interests, broadly understood,
31 but also that a threshold of harm be identified, below which decisions should not be tolerated [11].
32 Parents (or guardians) are also recognized to have a responsibility to foster their children’s
33 autonomy and moral growth, a responsibility clinicians share. Providing information in a
34 developmentally appropriate way that respects the minor patient’s cognitive ability, engaging the
35 child in decision making to the extent possible, and seeking the child’s assent to proposed
36 interventions helps to fulfill that responsibility [11].
37

38 With respect to DSD specifically, it has been suggested that decisions should seek to foster the
39 well-being both of the current child and the adult he or she will become; respect the rights of
40 patients to participate or make decisions that affect them; and foster family and parent-child
41 relationships [4].
42

43 In cases of DSD, decisions about a child’s best interests and appropriate interventions involve
44 sensitive issues of sex, gender, and sexuality, and interventions that may be irreversible. Parents are
45 often concerned about the future well-being of their child with regard to self-identity, relationships,
46 and reproductive capacity [7]. Because of these concerns, they may be quick to want to establish
47 sex and gender identity for their child in order to promote “normalcy” and reduce stigmatization.
48 Moreover, when physicians perceive early intervention to be urgently needed or wholly beneficial,
49 they may not fully recognize that there is a decision to be made, or the complexity of that decision
50 for the family and patient.

1 A 2013 lawsuit, though unsuccessful, raised constitutional issues with respect to early surgical
2 intervention and sex assignment. In 2013, the adoptive parents of a South Carolina child, MC, born
3 with “ovotesticular DSD” filed suit in the US District Court for the District of South Carolina
4 against physicians who had performed feminizing genitoplasty on the child at age 16 months. At
5 the time of surgery, MC was under the legal custody of the South Carolina Department of Social
6 Services, which authorized the intervention. Despite initially being raised as a girl by his adoptive
7 parents, consistent with his surgically assigned sex, MC identified as a boy and at the time the
8 lawsuit was filed was living as a boy. Because of the surgery, MC is now sterile. Although the
9 action was dismissed on appeal by the US Court of Appeals for the Fourth Circuit (in January
10 2015) [12], the lower court had denied the defendants’ request for dismissal on the grounds that the
11 defendants may have violated MC’s constitutional right to procreate [13].
12

13 RECOMMENDATION

14
15 The Board of Trustees recommends that the following be adopted in lieu of Resolution 3-A-16 and
16 the remainder of this report be filed:
17

18 That our American Medical Association support optimal management of DSD through
19 individualized, multidisciplinary care that: (1) seeks to foster the well-being of the child and
20 the adult he or she will become; (2) respects the rights of the patient to participate in decisions
21 and, except when life-threatening circumstances require emergency intervention, defers
22 medical or surgical intervention until the child is able to participate in decision making; and
23 (3) provides psychosocial support to promote patient and family well-being. (New HOD
24 Policy)

Fiscal Note: Less than \$500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-I-16

Subject: Medical Reporting for Safety-Sensitive Positions
(Resolution 14-A-16)

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 At the 2016 Annual Meeting, the American Medical Association (AMA) House of Delegates
2 (HOD) referred to the Board of Trustees Resolution 14-A-16, “Medical Reporting for Safety
3 Sensitive Positions,” which was introduced by the Aerospace Medical Association. Resolution 14-
4 A-16 asked:

5
6 That our American Medical Association advocate for a uniform national policy on mandatory
7 reporting of significant medical conditions for employees in Safety Sensitive positions to
8 protect public safety, as well as to enhance protection of reporting physicians.
9

10 Testimony was supportive of the intent of the resolution, but was concerned about the ambiguity of
11 language in light of the complexity of the issue. Testimony also offered an amendment to use the
12 Department of Transportation’s definition of “Safety-Sensitive Position.” It was expressed that,
13 while addressing this issue as timely and necessary, clarification must be provided before the
14 resolution is recommended for adoption.
15

16 **BACKGROUND**
17

18 According to the Department of Transportation (DOT), a safety-sensitive position is a job or
19 position where the employee holding this position has the responsibility for his or her own safety or
20 other people’s safety. Under DOT regulations, this term is currently used to describe positions that
21 are subject to drug and alcohol testing. These regulations cover transportation employees in various
22 capacities, including aviation, trucking, rail, mass transit, pipeline, and maritime professions [1].
23

24 The DOT requires that employees in safety-sensitive positions be given approval to work by a
25 certified physician. Qualifications for physician certification are regulated by the various agencies
26 of the DOT. For example, the Federal Aviation Administration (FAA) has regulations for the
27 certification of Aviation Medical Examiners [2]. The Federal Motor Carrier Safety Administration
28 has a registry and certification process for physicians who perform medical exams for truck drivers
29 [3]. Once certified, these physicians grant medical certificates to safety-sensitive employees,
30 allowing them to work. The requirements for safety-sensitive positions depend on the job’s duties
31 and are regulated by the various agencies of the DOT. Employees must be free of certain
32 disqualifying conditions, such as poor vision or hearing, epilepsy, or diabetes [4]. Furthermore,
33 there is no requirement that physicians report to the relevant agencies; rather, if an employee is not
34 eligible for work, the physician is expected not to grant a certificate to work.

1 Mandatory reporting by physicians is required by states in other contexts in which there is concern
 2 for public health or safety, such as certain infectious diseases or neurological conditions (e.g.,
 3 epilepsy) that may impair the driving ability of individuals who hold noncommercial motor vehicle
 4 licenses. Specific reporting requirements vary by state.

5
 6 Professional organizations also have their own recommendations for reporting when a threat to
 7 public safety exists. For example, the Federation of State Physician Health Programs recommends
 8 immediate reporting to the licensing authority by the state physician health program (PHP) if a
 9 physician enrolled in the PHP has an impairing condition and refuses to cease practice or otherwise
 10 presents a threat to public safety. Similarly, the physician must be reported if he or she rejects
 11 recommendations for evaluation or treatment or has been directed by the licensing authority to
 12 undergo evaluation or treatment. Although the safety of individual patients and the public may be
 13 the primary consideration, protecting the confidentiality of the impaired physician is also an
 14 important consideration [5].

15
 16 CURRENT AMA POLICY

17
 18 AMA policy does not speak to safety-sensitive positions specifically. However, the following
 19 address issues of mandatory reporting in the context of public health and safety.

- 20
 21 • Opinion 1.2.6, “Work-Related and Independent Medical Examinations,” addresses the unique
 22 relationships industry-employed physicians have with patients, often confined to the isolated
 23 examination required by the industry employer. Physicians are encouraged to disclose the
 24 limited nature of the patient-physician relationship, and to be forthright with the patient about
 25 the physician’s contractual role with the employer. The physician must maintain professional
 26 standards of confidentiality, and, when necessary, should assist the patient in connecting with a
 27 qualified physician or in pursuing follow-up care.
 28 • Opinion 3.2.3, “Confidentiality: Industry-Employed Physicians and Independent Medical
 29 Examiners,” urges that, when a physician assesses an individual’s health or disability for work-
 30 related illness or injury, the information must remain confidential unless consent is given by
 31 the individual or is required by law. When authorized to release medical information,
 32 physicians should only release information that is reasonably relevant to the individual’s ability
 33 to perform work.
 34 • Opinion 8.2, “Impaired Drivers and Their Physicians,” urges a physician to assess at-risk
 35 patients for conditions that may affect their driving ability. If such a risk exists, a physician
 36 should discuss driving risks with the patient and the patient’s family in order to minimize risk.
 37 The physician should notify the patient that continued driving against advice to stop will result
 38 in reporting to authorities, who will make the final determination on the status of the patient’s
 39 license. The physician should only disclose the minimum necessary information when
 40 reporting.
 41 • Opinion 9.3.2, “Reporting Impaired Colleagues,” discusses the situation in which a physician
 42 or mental health condition interferes with a physician’s ability to engage safely in professional
 43 activities, potentially compromising patient care. In such situations, physicians have an ethical
 44 obligation to intervene in a timely manner, to report colleagues in keeping with ethical
 45 guidance and applicable law, and to work collectively to support impaired physicians through
 46 the promotion of physician health and wellness and the creation of mechanisms to assist
 47 impaired physicians in ceasing their practice.
 48 • H-15.954, “Older Driver Safety,” urges physicians to adhere to their state’s reporting statutes
 49 for medically at-risk drivers.
 50 • H-15.958, “Fatigue, Sleep Disorders, and Motor Vehicle Crashes,” recommends collaboration
 51 between DOT and other agencies to study fatigue among truck drivers and operator other

1 commercial vehicles. It recommends that physicians become knowledgeable about sleep-
2 related disorders and inform patients of hazards of driving while fatigued, as well as becoming
3 aware of the laws and regulations concerning drivers in their state.
4

5 TARGETING MENTAL FITNESS CONCERNS 6

7 DOT regulations directly address mental health issues, such as substance use disorders and
8 depression, through the certification process, as well as through drug and alcohol testing. The DOT
9 also requires screening for other physically impairing conditions such as epilepsy or seizure
10 disorders through the medical certification process. Formal psychiatric examinations, however, are
11 not required [6]. In response to the Germanwings crash of 2015, Resolution 14-A-16 seeks to
12 address any gap in mental health screening among employees in safety-sensitive positions.
13

14 Following the Bureau d'Enquêtes et d'Analyse report, which confirmed the Germanwings crash of
15 2015 was caused by the suicide of a co-pilot known to have major depression with psychosis,
16 agencies around the world are working to improve mental health evaluations and treatment, as well
17 as encourage voluntary reporting of mental health issues. Several commercial airlines already have
18 mechanisms in place that allow pilots in distress to report, seek treatment, and return to work once
19 successfully evaluated [7].
20

21 In January of 2016, the Aviation Rulemaking Committee (ARC) of the FAA issued several
22 recommendations to the FAA, airlines, and pilots' unions. Collectively, they agreed to develop
23 programs to reduce mental health stigma and promote resources for treatment, including expanding
24 the use of pilot assistance programs to cover mental health. ARC concluded that routine screening
25 for depression is neither productive nor cost effective and therefore did not recommend it be
26 adopted. They instead advocated for education, outreach, and training in order to encourage self-
27 reporting to employers to enroll in treatment programs [7].
28

29 CONSIDERING A NATIONAL MANDATORY REPORTING POLICY 30

31 Transportation and safety-sensitive positions are primarily inter-state in nature at this time. Truck
32 drivers, pilots, and railroad workers operate in a capacity that affects the safety of people from
33 many different states. The intent of national mandatory reporting for safety-sensitive positions
34 would be to overcome the variability in state requirements.
35

36 However, it is not clear as a practical matter that such a policy would achieve the intended goal. A
37 study among primary care physicians in Canada found that they rarely report unsafe drivers to
38 licensing authorities, even when the reporting laws require it. The study surveyed vehicle crashes
39 and prior doctor visits to see how often doctors reported unsafe drivers before accidents occurred.
40 The study found that reporting was very low even though many of the drivers had been to their
41 physician before their crashes. The authors suggest that these findings are due to ambiguous
42 language in the statute, as well as the difficulty in detecting impairing conditions, such as alcohol
43 abuse, in a primary care context [8].
44

45 A national reporting mandate must be robustly structured to avoid unintended consequences, such
46 as damage to the reputation or employability of an individual inappropriately identified as
47 impaired. Among the minimum requirements needed for an effective reporting system would be
48 clearly delineated criteria for identifying individuals who pose a plausible, significant risk to public
49 safety and a clear mechanism for reporting such individuals to authorities in a position to take
50 action to protect the public. Appropriate safeguards to protect the confidentiality of individuals

1 identified as impaired and clear means for referring them for appropriate treatment would also be
2 required.

3

4 Whether the possible, but as yet unknown, gain in public safety would offset the additional burdens
5 national mandatory reporting would pose administratively for oversight authorities and for primary
6 care or other physicians who do not routinely screen patients for these purposes is uncertain. A
7 more limited approach may be more effective; for example, focusing on training the physicians
8 who currently carry out evaluation of individuals for safety-sensitive positions, such as Aviation
9 Medical Examiners and other certified physicians to better identify mental health issues during
10 their periodic evaluations of safety-sensitive employees.

11

12 CONCLUSION

13

14 National standards already exist for employees in safety-sensitive positions for their physical and
15 mental health, which require employees to be cleared for work by DOT-certified physicians. The
16 likely gain in public safety that would be achieved by mandatory reporting is at present
17 undemonstrated, while the burden on physicians who are not DOT-certified and not otherwise
18 required to report impairing conditions could be substantial.

19

20 RECOMMENDATION

21

22 The Board of Trustees recommends that Resolution 14-A-16, "Medical Reporting for Safety-
23 Sensitive Positions," not be adopted and the remainder of the report be filed.

REFERENCES

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7. Federal Aviation Administration. *Press Release – U.S. Commercial Aviation Community Targets Pilot Mental Fitness*. Available at http://www.faa.gov/news/press_releases/news_story.cfm?newsId=20456&omniRss=press_releasesAoc&cid=102_P_R. Accessed June 13, 2016.
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REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-I-16

Subject: Membership and Representation in the Organized Medical Staff Section--Updated Bylaws

Presented by: Colette R. Willins, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 At the 2016 Annual Meeting, our AMA House of Delegates adopted Policy G-615.101,
2 “Membership and Representation in the Organized Medical Staff Section,” introduced by the
3 Organized Medical Staff Section, which called for amendments to the AMA Bylaws to accomplish
4 the following:

- 5
- 6 1. An expanded member base, whereby all active AMA members who are members of the
7 medical staff of a hospital or a group of practicing physicians organized to provide health
8 care are eligible for OMSS membership. Also, Section membership shall continue to
9 include active resident and fellow members of the AMA who are selected by their medical
10 staffs as representatives to the OMSS business meeting.
- 11 2. A modified OMSS representation structure such that the medical staff of each hospital or
12 group of practicing physicians organized to provide health care may select up to two AMA
13 member representatives to the OMSS business meeting, with the president or chief of staff
14 of the medical staff also able to attend the meeting as a representative if he or she is an
15 AMA member.
- 16 3. When a multi-hospital system and its component medical staffs have exercised the option
17 under the Medicare Conditions of Participation to unify the medical staffs, the medical
18 staff members who hold specific privileges to practice at each separately Medicare-
19 certified hospital within the system may select up to two AMA member representatives to
20 the OMSS business meeting, with the president or chief of staff of the unified medical staff
21 also able to attend the meeting as a representative if he or she is an AMA member.
- 22 4. Certification of all representatives in accordance with procedures established by the OMSS
23 Governing Council.
- 24 5. Clarification of the rights of OMSS representatives, non-OMSS representatives, non AMA
25 members and guests.
- 26

27 The Council on Constitution and Bylaws presents the requested amendments to the AMA Bylaws.

28
29 RECOMMENDATIONS

30
31 The Council on Constitution and Bylaws recommends that the following amendments to the AMA
32 Bylaws be adopted, that Policy G-615.101 be rescinded, and that the remainder of this report be
33 filed. Adoption requires the affirmative vote of two-thirds of the members of the House of
34 Delegates present and voting.

- 1 **7.4 Organized Medical Staff Section.** The Organized Medical Staff Section is a delineated
2 Section.
3
- 4 **7.4.1 Membership.** Membership in the Section shall be ~~limited open to all active~~
5 physician members of the AMA who are members of a medical staff of a hospital
6 or a medical staff of a group of practicing physicians organized to provide
7 healthcare. physicians, including residents and fellows, selected by physician
8 members of the medical staffs of hospitals and other delivery systems. Selected
9 physicians who are not AMA members may participate in the Section's Business
10 Meeting as provisional members without the right to vote. Provisional members
11 may attend a maximum of 2 Business Meetings. Active resident and fellow
12 members of the AMA who are selected by their medical staffs as representatives to
13 the Business Meeting also shall be considered members of the Section.
14
- 15 **7.4.32 Representatives to the Business Meeting.** ~~The physician members of~~
16 ~~the~~ Each medical staff of each a hospital and each medical staff of a group of
17 practicing physicians organized to provide healthcare delivery system meeting the
18 requirements established by the Governing Council may select one or more up to
19 two active physician AMA member representatives to the Business Meeting. The
20 president or chief of staff of a medical staff may also attend the Business Meeting
21 as a representative if he or she is an active physician member of the AMA. The
22 representatives must be physician members of the medical staff of a hospital or
23 group of practicing physicians organized to provide healthcare or residents/fellows
24 affiliated with the medical staff of a hospital or group of practicing physicians
25 organized to provide healthcare delivery system. Selected physicians who are not
26 AMA members may participate in the Business Meeting as provisional
27 representatives without the right to vote. Provisional representatives may attend a
28 maximum of 2 Business Meetings. Selected All representatives to the Business
29 Meeting shall be properly certified by the President or Secretary of the medical
30 staff in accordance with procedures established by the Governing Council and
31 approved by the Board of Trustees.
32
- 33 **7.4.32.1** When a multi-hospital system and its component medical staffs have
34 unified the medical staffs, those medical staff members who hold specific
35 privileges to practice at each separate entity within the unified system may
36 select up to two representatives to the Business Meeting, so long as they
37 are active physician members of the AMA. The president or chief of staff
38 of a unified medical staff also may attend the Business Meeting as a
39 representative if he or she is an active physician member of the AMA.
40
- 41 Members of the Governing Council who have completed their terms and
42 the chairs of state association hospital medical staff sections or organized
43 medical staff sections may be seated as ex-officio representatives to the
44 Business Meeting, provided they are AMA members and are properly
45 certified by the President or Secretary of the state association. Ex-officio
46 representatives have the right to speak and debate in the meeting but do
47 not have the right to introduce business, introduce an amendment, make a
48 motion, or vote.

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~~7.4.3.2 All past chairs of the AMA Organized Medical Staff Section may attend the Business Meeting as ex officio members. They shall have the right to speak and debate in the meeting, but do not have the right to introduce business, introduce an amendment, make a motion, or vote.~~

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

7.4.4 Member Rights and Privileges

7.4.4.1 An OMSS member who is certified as a representative in accordance with 7.4.2 has the right to speak and debate, and has the right to introduce business, make motions, vote, and run for office to the OMSS Governing Council.

7.4.4.2 An OMSS member who is not certified as a representative in accordance with 7.4.2 has the right to speak and debate, but does not have the right to introduce business, make motions, vote or run for office to the OMSS Governing Council.

7.4.4.3 A physician who is not an AMA member may attend one Business Meeting as a guest, without the right to speak or debate, introduce business, make motions, vote or run for office to the OMSS Governing Council.

7.4.4.4 At the discretion of the Governing Council, a nonphysician may attend the Business Meetings as a guest.

(Modify AMA Bylaws)

Fiscal note: Less than \$500

AMA Policy

G-615.101 – Our AMA Bylaws will be amended to reflect the following statements about membership and representation in the Organized Medical Staff Section (OMSS):

1. Membership. Membership in the OMSS shall be open to all active physician members of the AMA who are members of the medical staff of a hospital or members of the medical staff of a group of practicing physicians organized to provide health care. Membership in the Section also shall continue to include active resident and fellow members of the AMA who are selected by their medical staffs as representatives to the OMSS business meeting.
2. Representation. a. The medical staff of each hospital or group of practicing physicians organized to provide health care meeting the requirements established by the OMSS Governing Council may select up to two AMA member representatives to the OMSS business meeting; additionally, the president or chief of staff of the medical staff may attend the meeting as a representative if he or she is an AMA member. b. When a multi-hospital system and its component medical staffs have exercised their option under the Medicare Conditions of Participation to unify the medical staffs, the medical staff members who hold specific privileges to practice at each separately Medicare-certified hospital within the system may select up to two AMA member representatives to the OMSS business meeting. Additionally, the president or chief of staff of the unified medical staff may attend the meeting as a representative if he or she is an AMA member. c. All OMSS representatives shall be certified in accordance with procedures established by the OMSS Governing Council.
3. Rights of OMSS representatives. Only certified OMSS representatives shall have the right to introduce business, make motions, and vote at OMSS business meetings, and to serve as members of the OMSS Governing Council.
4. Rights of non-OMSS representatives. a. OMSS members who are not certified OMSS representatives, as well as all other AMA members, shall have the right to attend OMSS business meetings and to speak and debate but not to introduce business, make motions, or vote. b. A physician who is not an AMA member may attend one business meeting as a guest, without the right to speak or debate, introduce business, make motions, or vote at OMSS business meetings. c. At the discretion of the Governing Council, non-physicians may attend business meetings as guests, without the right to speak or debate, introduce business, make motions, or vote.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-I-16

Subject: Bylaw Amendments pertaining to Late Resolutions and Emergency Business

Presented by: Colette R. Willins, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 At the 2016 Annual Meeting of the AMA House of Delegates, the House adopted Policy
2 G-600.054, “Procedures of the House of Delegates,” which recommended changes in how the
3 House of Delegates handles late and emergency resolutions from delegates. Policy G-600.054(6),
4 derived from Speakers Report 2-A-16, defined late resolutions as those submitted less than 30 days
5 before the opening day of a House of Delegates meeting but before the opening session recesses
6 and not meeting the definition of regular business. Policy G-600.054(6) defined resolutions from
7 delegates that are submitted after the recess of the opening session as emergency resolutions,
8 subject to a three-fourths vote for acceptance as business. Emergency resolutions are not referred to
9 a reference committee but rather handled by the House as a whole. For adoption, emergency
10 resolutions, like late resolutions, would require only a simple majority.

11
12 The Council on Constitution and Bylaws was asked to prepare bylaws amendments to effect the
13 changes in definitions of late and emergency resolutions as well as handling of late resolutions and
14 emergency resolutions from delegates. As part of that undertaking, the Council also was directed to
15 consider whether some elements currently in the bylaws related to the handling of late and
16 emergency business would be more appropriately defined in policy.

17 18 DISCUSSION

19 20 *Bylaw Changes to Incorporate House Action on Late and Emergency Resolutions—* 21 *Recommendation 1*

22
23 Several subprovisions of Bylaw 2.11.3, “Introduction of Business,” deal exclusively with late
24 and/or emergency resolutions (Bylaws 2.11.3.1.3 and 2.11.3.1.4). In its Recommendation 1, the
25 Council has proposed bylaw amendments that are consistent with Policy G-600.054(6). For Bylaw
26 2.11.3.1.4, the Council has also proposed retitling the heading for accuracy to read “Emergency
27 Resolutions.” Similarly, the Council proposes to modify Bylaw 2.11.3.2, “Reports of Board” to
28 “Business of the Board of Trustees” for accuracy.

29
30 The Council notes that existing Bylaw 2.11.5.2, “New Business on the Final Day of the House of
31 Delegates Meeting,” is now obsolete due to Policy G-600.065(7), which changed how emergency
32 resolutions are handled. Emergency resolutions are no longer referred to a reference committee
33 and, once accepted as business by the House of Delegates by a three-fourths vote of delegates
34 present and voting, require only a majority vote for adoption. Thus, the Council proposes to
35 incorporate much of the language from 2.11.5.2 into an amended 2.11.3.1.4, “Emergency
36 Resolutions,” and proposes a new Bylaw 2.11.3.1.6, “Resolutions not Accepted” to incorporate the
37 language of 2.11.5.2.2, but also modify it for clarity to state that resolutions that the House voted to

1 not accept can be resubmitted for possible consideration at any future meeting of the House of
2 Delegates rather than just at the next meeting.

3
4 Amended Bylaws 2.11.4 and 2.13.1.7.1 reiterate and clarify that items of business, with few
5 exceptions such as informational reports, memorial resolutions, etc., that have been submitted prior
6 to the recess of the opening session of the House of Delegates and accepted as business are referred
7 to a reference committee.

8
9 The criteria for considering and adopting emergency resolutions were changed with adoption of
10 Speakers Report 2-A-16. The timing regarding when these items are considered emergency
11 resolutions was also changed. Per Speakers Report 2-A-16, late resolutions continue to be subject
12 to a two-thirds vote for acceptance as business and upon acceptance, are referred to a reference
13 committee. Emergency resolutions are not referred to a reference committee but rather handled by
14 the House of Delegates as a whole. For adoption, late resolutions and emergency resolutions, like
15 all other items of business with the exceptions of amendments to the AMA Constitution and
16 Bylaws and changes to the Principles of Medical Ethics, require only a majority vote.

17
18 Because emergency resolutions must be processed without the benefit of a reference committee
19 hearing, their acceptance should meet a higher hurdle. At the same time, a situation that is truly
20 emergent and that requires action before the next meeting of the House of Delegates should
21 generally be self-evident presumably rendering the three-fourths vote largely a formality.

22
23 Previously, resolutions presented on the final day of the meeting were not considered late, but
24 rather emergency resolutions. The change in the definition of emergency resolutions eliminated
25 using the “final day of the House” as the time at which resolutions are considered emergency, and
26 instead set the time as after the close of the opening session of the House of Delegates. Speakers
27 Report 2 noted that the “final day of the House” is not known with certainty, as in recent years the
28 House has adjourned a day early multiple times.

29
30 According to Speakers Report 2, “The committee believes that establishing an unambiguous cut-off
31 for defining late and emergency resolutions will be of obvious value. Reference committee
32 hearings on a resolution are essential to the House of Delegates process and should only be
33 bypassed for emergency resolutions. Therefore the defining point favored here for late resolutions
34 is recess of the first session of the House of Delegates.”

35
36 *Elimination of References to “The Final Day” as a Defining Point for Other Business—*
37 *Recommendation 2*

38
39 During its comprehensive review of the AMA Bylaws and concurrent review of the House of
40 Delegates Reference Manual: Procedures, Policies and Practices, the Council considered
41 eliminating references to the final day when defining emergency resolutions but noted there are
42 many other items of business that had different rules for consideration and/or adoption using “the
43 final day of the House of Delegates meeting” as the defining point in our bylaws.

44
45 As noted above, Speakers Report 2 stated that the “final day of the House” is not known with
46 certainty, as in recent years the House has adjourned a day early multiple times. The Council
47 agrees that reference committee hearings are essential to the House of Delegates process and feels
48 they should only be bypassed for extraordinary business, not just emergency resolutions. The
49 Council also agrees that establishing an unambiguous cut-off for defining when an item is beyond
50 “late” will be of obvious value. Therefore the defining point favored here for late resolutions, the

1 recess of the first session of the House of Delegates, should be applied to other items of business
2 that currently use the defining point of “the final day.”
3

4 In proposing the bylaw amendments in Recommendation 2, the Council offers the following
5 rationale for its recommendations, and notes that the House has the ability to adopt, adopt as
6 amended, not adopt, refer, etc.
7

- 8 • 2.11.3.1.2, AMA Sections. The Council believes that it is appropriate to change the cut-off
9 point for resolutions from sections from “the close of business on the day preceding the
10 final day of the meeting” to “no later than the recess of the House of Delegates opening
11 session.” The Council has also conferred with the Office of the House of Delegate Affairs
12 and confirms that the Council’s proposed language is consistent with the sections’ current
13 practice of submitting resolutions before the opening of the House of Delegates so that
14 resolutions can be included in the Sunday tote, accepted as business and referred to a
15 reference committee for discussion.
16
- 17 • 2.11.3.3, Reports of Councils. Currently, reports, opinions or recommendations from a
18 council of the AMA or a special committee of the House of Delegates may be presented at
19 any time before the close of business on the day preceding the final day of a meeting. The
20 Council felt that the language referring to the final day must be eliminated since the “final
21 day of the House” is not known with certainty. However, it is not as simple as substituting
22 the new defining point. Unlike business from the Board presented on the final day which
23 requires a three-fourths vote for adoption, business from the councils simply is not allowed
24 on the final day under our current bylaws. It was felt that these groups should be able to
25 present items of business after the recess of the House of Delegates opening session. To
26 avoid this unintended consequence, the council eliminated the final day language which
27 then allows these council and special committee items of business to be presented at any
28 time during a meeting.
29
- 30 • 2.11.5 and 2.11.5.1, New Business presented after recess of the opening session of the
31 House of Delegates meeting. The Council has deleted reference to “final day” and instead
32 used the defining point of business presented after the recess of the opening session of the
33 House of Delegates. At that point in time, the business will be presented too late for
34 reference committees. The current higher bar of three-fourths vote for adoption still stands
35 as it is currently in our Bylaws. While Speakers Report 2 gave an excellent explanation
36 why the final day could no longer be used as a defining point, it made no recommendations
37 regarding changing the higher bar for consideration currently set for business other than
38 resolutions from delegates.
39

40 *Other Considerations*

41
42 As directed by Policy G-600.054, the Council has considered whether some bylaw provisions
43 would better exist in policy. The Council discussed whether or not the voting threshold to accept
44 late resolutions and/or emergency resolutions for consideration should continue to be embodied in
45 the Bylaws or be solely in the HOD Reference Manual: Procedures, Practices and Policies, and
46 agreed to retain them in the Bylaws for completeness as well as include them in the HOD
47 Reference Manual. The Council, however, has elected not to specify in the Bylaws the vote
48 required for adoption.

1 RECOMMENDATIONS

2
3 The Council on Constitution and Bylaws recommends the following:

- 4
5 1. That the following amendments to the AMA Bylaws be adopted consistent with Policy
6 G-600.054(6):

7
8 **2.11.3 Introduction of Business.**

9
10 **2.11.3.1 Resolutions.** To be considered as regular business, each resolution must be
11 introduced by a delegate or organization represented in the House of
12 Delegates and must have been submitted to the AMA not later than 30 days
13 prior to the commencement of the meeting at which it is to be considered,
14 with the following exceptions.

15
16 **2.11.3.1.1 Exempted Resolutions.** If any member organization's house of
17 delegates or primary policy making body, as defined by the
18 organization, adjourns during the 5-week period preceding
19 commencement of an AMA House of Delegates meeting, the
20 organization is allowed 7 days after the close of its meeting to
21 submit resolutions to the AMA. All such resolutions must be
22 received by noon of the day before the commencement of the
23 AMA House of Delegates meeting. The presiding officer of the
24 organization shall certify that the resolution was adopted at its
25 just concluded meeting and that the body directed that the
26 resolution be submitted to the AMA House of Delegates.

27 ***

28
29 **2.11.3.1.3 Late Resolutions.** Late resolutions may be presented by a
30 delegate prior to the recess of the opening session of the House
31 of Delegates any time prior to the final day of a meeting, and but
32 will be accepted as business of the House of Delegates only
33 upon two-thirds vote of delegates present and voting.

34
35 **2.11.3.1.4 Emergency Nature Resolutions.** On the final day of a meeting,
36 delegates may present resolutions of an emergency nature which
37 shall be accepted pursuant to Bylaw 2.11.5.2. Resolutions of an
38 emergency nature may be presented by a delegate any time after
39 the opening session of the House of Delegates is recessed.
40 Emergency resolutions will be accepted as business only upon a
41 three-fourths vote of delegates present and voting, and if
42 accepted shall be presented to the House of Delegates without
43 consideration by a reference committee.

44
45 **2.11.3.1.5 Withdrawal of Resolutions.** A resolution may be withdrawn by
46 its sponsor at any time prior to its acceptance as business by the
47 House of Delegates.

48
49 **2.11.3.1.6 Resolutions not Accepted.** Late resolutions and emergency
50 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.

2.11.3.2 Reports Business of the Board of Trustees. Reports, recommendations, resolutions or other new business, may be presented by the Board of Trustees at any time during a meeting.

2.11.4 Referral to Reference Committee. Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates before the close of business on the day preceding the final day of a meeting shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates. Items of business presented after the recess of the opening session are not referred to reference committee, but rather heard by the House of Delegates as a whole, subject to acceptance as business of the House of Delegates. Informational items are not referred to a reference committee.

~~**2.11.5.2 Emergency Resolutions.** Resolutions of an emergency nature presented by delegates on the final day of a meeting shall be referred by the Speaker to an appropriate reference committee, which shall then report to the House of Delegates as to whether the matter involved is or is not of an emergency nature.~~

~~**2.11.5.2.1** If the reference committee reports that the matter is of an emergency nature, the resolution shall be presented to the House of Delegates without further consideration by a reference committee. Adoption of the recommendation(s) in the emergency resolution shall require a three-fourths vote of delegates present and voting.~~

~~**2.11.5.2.2** If the reference committee reports that the matter is not of an emergency nature, the resolution may be submitted for consideration at the next meeting in accordance with the procedure in Bylaw 2.11.3.~~

2.13.1 Reference Committees of the House of Delegates.

2.13.1.7 Procedure and Reports.

2.13.1.7.1 Method. Resolutions, reports, extracted opinions and proposals presented to the House of Delegates prior to the recess of the opening session of the House of Delegates shall be referred to appropriate reference committees, subject to acceptance as business of the House of Delegates. The reports of reference committees shall be presented to the House of Delegates before final action may be taken on such resolutions, reports and

proposals, unless otherwise provided in these Bylaws, or unless otherwise unanimously decided by the House of Delegates.

(Modify AMA Bylaws)

2. That the following amendments to the AMA Bylaws be adopted:

2.11 Procedure.

2.11.3 Introduction of Business.

2.11.3.1 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 30 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1 Exempted Resolutions. If any member organization's house of delegates or primary policy making body, as defined by the organization, adjourns during the 5-week period preceding commencement of an AMA House of Delegates meeting, the organization is allowed 7 days after the close of its meeting to submit resolutions to the AMA. All such resolutions must be received by noon of the day before the commencement of the AMA House of Delegates meeting. The presiding officer of the organization shall certify that the resolution was adopted at its just concluded meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.

2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates no later than the recess of the House of Delegates opening session. ~~At any time before the close of business on the day preceding the final day of the meeting.~~

2.11.3.2 Reports of Board of Trustees. Reports, recommendations, resolutions or other new business, may be presented by the Board of Trustees at any time during a meeting.

2.11.3.3 Reports of Councils. Reports, opinions or recommendations from a council of the AMA or a special committee of the House of Delegates may be presented at any time ~~before the close of business on the day preceding the final day of~~ during a meeting.

2.11.3.4 Informational Reports of Sections. Informational reports may be presented by the AMA Sections on an annual basis.

1 **2.11.5 ~~New Business on Final Day of~~ New Business Presented After Recess of the Opening**
2 **Session of the House of Delegates Meeting.**
3

4 **2.11.5.1 Requirements.** Reports, recommendations, resolutions or other new
5 business presented by the Board of Trustees after recess of the opening
6 session of the House of Delegates meeting on the final day of a
7 ~~meeting~~ shall be accepted as business before the House and shall not
8 be referred to a reference committee, but adoption of the
9 recommendation(s) in the report or other item(s) of business shall
10 require a three-fourths vote of delegates present and voting.
11

12 (Modify AMA Bylaws)

- 13
- 14 3. That Policy G-600.054(6) and (7) be rescinded; and
- 15
- 16 4. That the balance of this report be filed.

Fiscal Note: Less than \$500

RELEVANT AMA POLICY

G-600.054 - Procedures of the House of Delegates

1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.
2. The rules and procedures of the House of Delegates will be amended as follows:
 - A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.
 - B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.
3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.
4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.
5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.
6. Late resolutions are defined as those submitted less than 30 days before the opening day of a House of Delegates meeting but before the opening session recesses and not meeting the definition of regular business, and that business submitted after the recess of the opening session be regarded as emergency business, subject to a three-fourths vote for acceptance as business.
7. The Council on Constitution and Bylaws will prepare bylaws amendments to effect the changes in definitions as well as handling of late resolutions and emergency business and as part of that effort consider whether some related elements currently in the bylaws would better exist in policy.
8. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly.

REPORT 1 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (1-I-16)
Collaborative Care
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

Traditionally, the practice of medicine was conceived as a single physician providing care directly to an individual patient. But as health care focuses increasingly on quality, efficiency, and the experiences and outcomes of the patient, services are no longer necessarily provided by a single physician. Rather, a patient's care now often lies in the hands of many collaborating health care professionals.

Teams that collaborate effectively can enhance the quality of care for individual patients. By being prudent stewards and delivering care efficiently, teams also have the potential to expand access to care for populations of patients. Physicians are uniquely situated to serve as clinical leaders. By virtue of their thorough and diverse training, experience, and knowledge, physicians have a distinctive appreciation of the breadth of health issues and treatments that enables them to synthesize the diverse professional perspectives and recommendations of the team into an appropriate, coherent plan of care for the patient.

As leaders within health care teams physicians have a responsibility to model ethical leadership, promote core team values, support transparent decision making, encourage open discussion and shared accountability, and respect the patient's and family's unique relationship as team members. As leaders within health care institutions, physicians should advocate for the resources and support health care teams need to function effectively, encourage institutions to identify and address barriers to collaboration, and promote policies and procedures to constructively address conflicts that adversely affect patient care.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-I-16

Subject: Collaborative Care

Presented by: Ronald A. Clearfield, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 Traditionally, the practice of medicine was conceived as a single physician providing care directly
2 to an individual patient. But as health care focuses increasingly on quality, efficiency, and the
3 experiences and outcomes of the patient, services are no longer necessarily provided by a single
4 physician. Rather, a patient's care now often lies in the hands of many collaborating health care
5 professionals. Teams may be formal structured units or ad hoc groups of physicians, nurses, social
6 workers and other health professionals, at one or several sites of care, all of whom play various
7 clinical and administrative roles in the care of a single patient.

8
9 Systemic changes in the nation's health care system are also driving the movement toward
10 collaborative care as a tool for pursuing coordinated, patient-centered care [1]. Collaborative care
11 has been tested and measured in clinical settings around the country and its importance has been
12 translated into law and policy [2, 3]. A growing body of research indicates that collaborative care
13 can enhance health care quality and outcomes for individual patients, may enhance access to care,
14 and may help lower—or slow the rate of increase of—health care costs [4, 5, 6, 7]. Further, well-
15 functioning teams that provide safe, efficient, high-quality care can reduce burnout and improve
16 morale among health care personnel [8].

17
18 This report examines key ethical considerations for health care teams engaged in providing care
19 collaboratively and develops guidance for physicians as leader-members of care teams.

20 21 ETHICAL PRINCIPLES FOR COLLABORATIVE CARE

22
23 A well-functioning team capable of optimizing patient outcomes is defined by dedication to
24 providing patient-centered care, protecting the integrity of the patient-physician relationship,
25 sharing mutual respect and trust, communicating effectively, sharing accountability and
26 responsibility, and upholding common ethical values as team members.

27 28 *Patient-Centered Care*

29
30 Collaborative care is first and foremost patient-centered care. The physician's duty to hold the
31 patient's interests paramount (Principle VIII) does not diminish when care is provided by
32 professionals working as a team. Like individual health care professionals, teams must ensure that
33 the care they deliver aligns with the values and needs of the patient [9]. Teams must support

* 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 patients as decision makers (and families where appropriate) and afford them opportunities to
2 participate actively in treatment as members of the team. Patients and their families should feel
3 they are understood and respected by the health professionals who provide care. They must be able
4 to ask questions and must be confident that all health care personnel will address any issues openly
5 and honestly.

6 7 *Protecting the Patient-Physician Relationship*

8
9 The patient-physician relationship remains central in collaborative care environments, just as in any
10 other health care setting [9]. Physicians remain advocates for their patients and are responsible for
11 putting the patient's welfare above obligations to others [10]. The relationship that the team as a
12 whole has with the patient should be supportive of the interaction between the patient and
13 physician.

14 15 *Mutual Respect and Trust*

16
17 To provide efficient, effective care, all members of a health care team must contribute actively,
18 which requires that members mutually respect and trust one another. Health care professionals
19 must be confident that their colleagues are performing at their highest standard of practice, and that
20 the team, overall, is providing optimal care. When members do not respect and trust one another,
21 individual contributions can be misinterpreted or ignored, leading to tension or lapses in
22 communication that can in turn compromise a patient's health and safety. Members of a well-
23 functioning team will acknowledge and appreciate the contributions made by each and every team
24 member [9]. Mutual respect and trust strengthen the clinical team and give all members an
25 opportunity to serve as positive role models for one another and to inspire and motivate their
26 colleagues [9]. Honoring the work of one's colleagues not only underscores the importance of
27 individual contributions, but also emphasizes the contribution of the team as a cohesive unit [9].
28

29 *Effective Communication*

30
31 Effective communication is fundamental to providing safe, optimal care to patients [9]. Every
32 member of the team shares the responsibility to communicate effectively, clearly, and consistently.
33 Physicians can play a leading role by modeling effective communication strategies. When
34 physicians provide clear, concise information or instructions to colleagues they demonstrate
35 behaviors that others on the team can utilize to communicate efficiently and effectively themselves
36 [9].
37

38 *Accountability*

39
40 Accountability is likewise a core ethical principle for collaborative care. Given the fiduciary nature
41 of the patient-physician relationship as well as the expectations society places on physicians
42 because of their knowledge and training, physicians are accountable for patient care and outcomes
43 [9]. Nonetheless, all members of the team are accountable for their individual practice and each
44 shares responsibility for the functioning of the team as a whole, while protecting patient well-being
45 and ensuring that the team focuses on patient care as the common goal.
46

47 Beyond accountability to individual patients, physicians and health care teams also have a
48 responsibility to the communities in which they work to be prudent stewards of community
49 resources [11]. Physicians and teams have a responsibility to ensure that providing care
50 collaboratively not only benefits individual patients, but also helps to achieve efficiency and value
51 for the health care system to benefit the whole community.

1 KEY ATTRIBUTES OF EFFECTIVE TEAM MEMBERS

2
3 The attributes that individual members bring to a team are also important for effective team
4 functioning. The Institute of Medicine, for example, suggests the following five key attributes:
5 honesty, discipline, creativity, humility, and curiosity [1].

6
7 Within a successful team, members are honest and transparent about goals, decisions, mistakes, and
8 fears [1], and engage in open dialogue that creates mutual trust [12].

9
10 A functional team also has disciplined members, with each performing assigned duties and sharing
11 new information with other members to improve individual and team operations [1]. They fulfill
12 responsibilities even when doing so is inconvenient or uncomfortable [1]. Such disciplined
13 performance allows members not only to comply with established protocols, but to develop mutual
14 respect and pursue improvement while doing so [1, 12].

15
16 Creativity is another important attribute that allows the team to work together effectively on
17 complicated health issues. Creativity involves team members enthusiastically engaging new
18 problems to find innovative solutions [1]. Further, creative teams do not view failed attempts and
19 negative outcomes as the destruction of team goals, but as opportunities to learn [1].

20
21 With humility, team members recognize differences in training among the group, but do not view
22 one form of training as wholly superior to all others [1]. Also, members understand that they are all
23 humans susceptible to making mistakes [12]. These attitudes enable members to rely on one
24 another, regardless of hierarchy [1], and to share constructive criticism to overcome professional
25 and ethical obstacles.

26
27 Lastly, effective members of collaborative care teams exhibit curiosity and actively use knowledge
28 gained from their daily lives toward the continuous improvement of individual and team efforts [1].

29
30 The composition of the team that delivers care—more or fewer physicians relative to other
31 clinicians, mix of expertise, etc.— may vary in different contexts, such as chronic versus acute care
32 or in-patient versus outpatient settings. For example, chronic illness is often managed most
33 effectively by a team whose membership is stable. In contrast, acute care, especially in-patient care,
34 is frequently provided by specialists who may work with different teams from day to day. Yet in
35 every context, an identified individual needs to play a leadership role and take responsibility for
36 collecting and synthesizing the diverse professional perspectives and recommendations of the team
37 into an appropriate, coherent plan for the patient [9]. In most contexts, a physician is best able to
38 serve as team leader.

39
40 LEADERSHIP BEHAVIOR AND CONCEPTS

41
42 An effective team requires a clinical leader who takes responsibility “for maximizing the expertise
43 and input of the entire team in order to provide the patient with comprehensive and definitive care”
44 [9]. Clinical leaders ensure that the team as a whole functions well and facilitates decision-making
45 [9], and is ultimately accountable to patients. Clinical leaders must use their training and
46 experience to interpret and synthesize the information provided by team members to make a
47 differential diagnosis and develop a plan of care. Effective clinical leaders foster common
48 understanding about responsibilities and encourage open communication among patients, families,
49 and the entire health care team.

1 Physicians are uniquely suited to serve as clinical leaders by virtue of their thorough and diverse
2 training, experience, and knowledge [9]. Their distinctive appreciation of the breadth of health
3 issues and treatment options in their field of practice also enables them to synthesize the diverse
4 professional perspectives and recommendations of the team into an appropriate, coherent plan of
5 care for the patient. This expertise, as well as patient expectations—which hold as much in a
6 setting of collaborative care as in a one-on-one office visit—make it most appropriate that a
7 physician serve as a team’s clinical leader although this does not necessarily mean that physicians
8 will take the helm for every aspect of decision-making or coordinate every detail of treatment.
9 Other health care personnel bring expertise and knowledge to the team and in many instances will
10 be in charge when their expertise is most needed [9].

11
12 Although traditional notions of liability map poorly against the changes taking place in how,
13 where, and by whom health care is delivered, physicians still can be held legally accountable for
14 the actions of medical personnel working under their supervision [13]. To this extent, it currently
15 makes sense from a legal perspective to have the physician serve as clinical leader. However, as
16 health care continues to evolve and roles become increasingly fluid there is need for a more
17 nuanced understanding of how teams and their members are mutually accountable to patients and
18 to one another over the course of a patient’s care, legally as well as ethically.

19
20 The role of clinical leader should be distinguished from that of clinical coordinator. While a
21 physician should be the clinical leader of the health care team, the clinical coordinator of the team
22 need not be. The clinical coordinator is the team member who, “based on his or her training,
23 competencies and experience, is best able to coordinate the services provided by the team so that
24 they are integrated to provide the best care for the patient” [9].

25 26 *Transactional versus transformational leadership*

27
28 The concepts of “transactional” versus “transformational” leadership offer a powerful framework
29 for thinking about physician leadership in the context of collaborative care. Briefly, transactional
30 leaders largely intervene in a “corrective” mode episodically when members deviate from a defined
31 standard [14]. Transformational leaders, in contrast, are continuously engaged in relationships that
32 inspire followers through charisma, clearly articulated visions, and ongoing personalized guidance
33 [14, 15]. In a clinical context, for example, a transformational physician leader might hold informal
34 five- to ten-minute “huddles,” in addition to weekly team meetings, to keep the team on the same
35 page [16].

36
37 Some evidence suggests that transformational leadership has positive effects on followers’ task
38 performance and perceptions of job characteristics and their leaders, and that such leadership
39 behaviors can be taught [14, 15, 17, 18]. Leadership behavior influences how well a team
40 functions. Clearly communicating a shared vision, connecting well to emotional needs, seeking
41 consensus and collaboration, role-modeling, or coaching can each enhance the effectiveness of a
42 team [19].

43 44 *Responsibilities as Individuals, Team Members & Institutional Leaders*

45
46 As clinical leaders in collaborative care, physicians have ethical responsibilities as individuals, as
47 members of the team, and as leaders in their institutions [12].

48
49 As individuals, physicians have a responsibility to respect other team members, understand their
50 own and other team members’ range of skill and expertise and role in the patient’s care, and master
51 broad teamwork skills [12]. Like all team members, physicians should be open to adopting insights

1 from other members. They should communicate respectfully with other team members, even in the
2 face of controversy, and should be welcoming to new members. Physicians can model ethical
3 conduct for fellow team members—e.g., by avoiding intimidating body language or speaking
4 disrespectfully about patients—and should encourage other team members to behave accordingly
5 [20].

6
7 As clinical leaders in health care teams, physicians are in a position to foster the key attributes of
8 effective team members and to promote respect among team members. They can and should help
9 clarify expectations so that the team can establish systematic and transparent decision making. As
10 leaders, physicians can likewise encourage open discussion of clinical and ethical concerns and
11 help ensure that every member’s opinion is heard and considered [21], and that team members
12 share responsibility and accountability for decisions and outcomes [12].

13
14 Teams need support and resources to optimize patient-centered care [12]. Such resources might
15 include additional training in teamwork skills, clerical support, flexibility in staff scheduling to
16 promote continuity of team membership, or additional staff to provide skills not already
17 represented among team members. Teams also need the organizations in which they provide care to
18 recognize and respect the unique relationship between team and patient. Further, explicit
19 recognition of effective teams by organizational leadership conveys the message that teamwork is
20 valued and important to the organization. Finally, teams need their organizations to provide fair
21 mechanisms for assessing the team’s performance [12]. As leaders within their institutions,
22 physicians should help ensure that teams are well supported and that their contributions to the
23 quality and patients’ experience of care are appropriately recognized.

24 25 CHALLENGES TO COLLABORATION

26
27 Teams can face a variety of challenges to effective collaboration, many of which are tied to the
28 culture and structure of the health care institution within which they work. Of particular concern,
29 teams may fall short of the goal of optimizing patient-centered care and outcomes when they lack
30 resources, when institutional barriers inhibit effective team functioning, and when there is ongoing
31 conflict within the team.

32 33 *Inadequate Resources*

34
35 While some individuals may naturally possess the necessary traits to work successfully in a team,
36 many others do not. Physicians have ultimate responsibility and expect accountability within a
37 team; development of team leadership skills will foster effective teamwork. Changes in how
38 physicians and other health care personnel are taught to view teamwork, such as the use of RACI
39 charts (which delineate who is Responsible, Accountable, Consulted, or Informed in the given
40 context)[22], as well as specific training in teamwork skills can reduce conflict and improve team
41 performance [23]. Ideally, interdisciplinary training begins early in medical education, a concept
42 that has been embraced by the medical community [24]; the Accreditation Council for Graduate
43 Medical Education identifies interpersonal and communication skills as a core competency. The
44 ACGME notes that these skills “result in effective information exchange and teaming with ...
45 professional associates” [23]. Organizations may also find it useful to implement their own training
46 for teamwork tailored to the culture of the institution. Such training can provide common
47 structures, processes and expectations for health care professionals who work together on a regular
48 basis.

49
50 Institutions also need to provide adequate administrative support for teams, promote scheduling
51 practices that help ensure workload and duty hours are distributed fairly across personnel, and

1 sustain stable team membership to the extent possible. Teams function best when they have input
2 into the structure and function of the institutions in which they practice.

3
4 *Institutional Culture*

5
6 The culture of an institution can also pose challenges for effective teamwork. In order to create a
7 practice environment that encourages collaborative care, an organization's leaders must actively
8 foster this new environment. Leaders must commit fully to change over the long term; adhering to
9 new methods of communication and teamwork requires diligence and oversight, lest old patterns
10 reemerge [25]. Organizations have the opportunity and responsibility to nurture supportive
11 environments by helping teams develop shared goals and establish and maintain clear roles within
12 the team. Leaders foster collaborative environments by being seen to value other health care
13 professionals in addition to physicians; fostering mutual trust within teams; supporting effective
14 communication and fair, objective measurement of processes focused on improving team function
15 and outcomes [1].

16
17 Health care institutions share accountability both to individual patients and to their communities for
18 ensuring high quality care, although other influences, including, prominently, the decisions and
19 policies of third-party payers, also may be involved. Physicians can play an important role in
20 holding institutions to this responsibility by advocating for the resources teams need to function
21 effectively and by identifying aspects of institutional culture that create barriers to effective
22 teamwork.

23
24 *Fluctuating Team Membership*

25
26 The complex nature of health care delivery means that a team's composition is not always constant
27 [26]. For example, in emergency care scenarios, teams often are abruptly created to address a
28 patient's imminent needs only to disband when the patient is transferred or discharged. An
29 institution's rotation of health care personnel can also lead to new teams continuously being
30 created, with each individual joining a new team during his or her next shift. Since trust and mutual
31 respect between team members is often built over time, a constant fluctuation of membership can
32 pose significant obstacles for effective team performance. Educating individual staff members on
33 the principles of effective teamwork enables them to bring their understandings to each newly
34 founded collaboration [1].

35
36 *Conflict within Teams*

37
38 Constructive debate is necessary for a group of individuals to come to a consensus on a
39 complicated health decision [12]. Because each team member adds a distinct perspective to the
40 team, conflict may arise when the team's decision is at odds with a member's training, experience,
41 or personal beliefs and values, or when a member's behavior hampers team performance [9, 12]. A
42 conflict resolution mechanism is needed when the degree of conflict interferes with team
43 performance [12].

44
45 Without institutional means to address conflicts, teams risk demise when members are unable to
46 voice their concerns and frustrations without fear of reprisal [12]. Conflicts that are not addressed
47 or resolved, or not handled fairly, undermine the team and degrade any trust and mutual respect
48 that has been built [25]. Because collaborative care has become essential to contemporary health
49 care, conflict must be minimized to prevent the reduction of team functionality [1]. Institutions
50 must establish standards for determining when conflict interferes with achieving the team's goals
51 and must be addressed and what procedures should be used to resolve the situation [9, 12].

1 RECOMMENDATION

2
3 In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the
4 following be adopted and the remainder of this report be filed:

5
6 In health care, teams that collaborate effectively can enhance the quality of care for individual
7 patients. By being prudent stewards and delivering care efficiently, teams also have the
8 potential to expand access to care for populations of patients. Such teams are defined by their
9 dedication to providing patient-centered care, protecting the integrity of the patient-physician
10 relationship, sharing mutual respect and trust, communicating effectively, sharing
11 accountability and responsibility, and upholding common ethical values as team members.
12

13 An effective team requires the vision and direction of an effective leader. In medicine, this
14 means having a clinical leader who will ensure that the team as a whole functions effectively
15 and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By
16 virtue of their thorough and diverse training, experience, and knowledge, physicians have a
17 distinctive appreciation of the breadth of health issues and treatments that enables them to
18 synthesize the diverse professional perspectives and recommendations of the team into an
19 appropriate, coherent plan of care for the patient.
20

21 As leaders within health care teams, physicians individually should:

22
23 (a) Model ethical leadership by:

- 24
25 (i) understanding the range of their own and other team members' skills and expertise and
26 roles in the patient's care;
27
28 (ii) clearly articulating individual responsibilities and accountability;
29
30 (iii) encouraging insights from other members and being open to adopting them; and
31
32 (iv) mastering broad teamwork skills.
33

34 (b) Promote core team values of honesty, discipline, creativity, humility, and curiosity and
35 commitment to continuous improvement.
36

37 (c) Help clarify expectations to support systematic, transparent decision making.
38

39 (d) Encourage open discussion of ethical and clinical concerns and foster a team culture in
40 which each member's opinion is heard and considered and team members share
41 accountability for decisions and outcomes.
42

43 (e) Communicate appropriately with the patient and family and respect their unique
44 relationship as members of the team.
45

46 As leaders within health care institutions, physicians individually and collectively should:

47
48 (f) Advocate for the resources and support health care teams need to collaborate effectively in
49 providing high-quality care for the patients they serve, including education about the
50 principles of effective teamwork and training to build teamwork skills.

- 1 (g) Encourage their institutions to identify and constructively address barriers to effective
2 collaboration.
3
- 4 (h) Promote the development and use of institutional policies and procedures, such as an
5 institutional ethics committee or similar resource, to address constructively conflicts within
6 teams that adversely affect patient care.
7
- 8 (New HOD policy)

Fiscal note: less than \$500

REFERENCES

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REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (2-I-16)
Competence, Self-Assessment and Self-Awareness
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient's well-being.

To fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients. As a profession, medicine should provide meaningful opportunity for physicians to hone their ability to be self-reflective.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-16

Subject: Competence, Self-Assessment and Self-Awareness

Presented by: Ronald A. Clearfield, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 The expectation that physicians will provide competent care is central to medicine. This
2 expectation shaped the founding mission of the American Medical Association (AMA) and runs
3 throughout the AMA *Code of Medical Ethics* [1-4]. It undergirds professional autonomy and the
4 privilege of self-regulation granted to medicine by society [5]. The profession promises that
5 practitioners will have the knowledge, skills, and characteristics to practice safely and that the
6 profession as a whole and its individual members will hold themselves accountable to identify and
7 address lapses [6-9].

8
9 Yet despite the centrality of competence to professionalism, the *Code* has not hitherto examined
10 what the commitment to competence means as an ethical responsibility for individual physicians in
11 day-to-day practice. This report by the Council on Ethical and Judicial Affairs explores this topic to
12 develop ethics guidance for physicians.

13 14 DEFINING COMPETENCE

15
16 A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional
17 assessments of physicians' technical knowledge and skills. However, this report is not concerned
18 with matters of technical proficiency assessed by medical schools and residency programs,
19 specialty societies (for purposes of board certification), or hospital and other health care institutions
20 (e.g., for privileging and credentialing). Such matters lie outside the council's purview.

21
22 The ethical responsibility of competence encompasses more than knowledge and skill. It requires
23 physicians to understand that as a practical matter in the care of actual patients, competence is fluid
24 and dependent on context. Importantly, the ethical responsibility of competence requires that
25 physicians at all stages of their professional lives be able to recognize when they are and when they
26 are not able to provide appropriate care for the patient in front of them or the patients in their
27 practice as a whole. For purposes of this analysis, competence is understood as "the habitual and
28 judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values,
29 and reflection in daily practice for the benefit of the individual and the community being served"
30 and as "developmental, impermanent, and context dependent" [10].

31
32 Moreover, the council is keenly aware that technical proficiency evolves over time—what is
33 expected of physicians just entering practice is not exactly the same as what is expected of mid-

* 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 career physicians or physicians who are changing or re-entering practice or transitioning out of
2 active practice to other roles. Each phase of a medical career, from medical school through
3 retirement, carries its own implications for what a physician should know and be able to do to
4 practice safely and to maintain effective relationships with patients and with colleagues.

5
6 The concept that informs this report differs as well from the narrower legal definition of
7 competence as the knowledge and skills an individual has to do a job. Rather, this report explores a
8 broader notion of competence that encompasses deeper aspects of wisdom, judgment and practice
9 that enable physicians to assure patients, the public, and the profession that they provide safe, high
10 quality care moment to moment over the course of a professional lifetime.

11 SELF-ASSESSMENT & ITS LIMITATIONS

12
13
14 Health care institutions and the medical profession as a whole take responsibility to regulate
15 physicians through credentialing and privileging, routinely testing knowledge (maintenance of
16 certification, requirements for continuing education, etc.) and, when needed, taking disciplinary
17 action against physicians who fail to meet expectations for competent, professional practice.
18 However, the better part of the responsibility to maintain competence rests with physicians’
19 “individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs
20 to maintain a level of competence commensurate with [their] clinical roles” [11].

21
22 Self-assessment has thus become “integral to many appraisal systems and has been espoused as an
23 important aspect of personal professional behavior by several regulatory bodies and those
24 developing learning outcomes for students” [12]. Undergraduate and graduate medical education
25 programs regularly use self-assessment along with third-party evaluations to ensure that trainees
26 are acquiring the knowledge and skills necessary for competent practice [5, 10, 13-16].

27
28 Yet how accurately physicians assess their own performance is open to question. Research to date
29 suggests that there is poor correlation between how physicians rate themselves and how others rate
30 them [5, 12, 13]. Various studies among health professionals have concluded that clinicians and
31 trainees tend to assess their peers’ performance more accurately than they do their own; several
32 have found that poor performers (e.g., those in the bottom quartile) tend to over-estimate their
33 abilities while high performers (e.g., those in the top quartile), tend to under-estimate themselves
34 [5, 12, 17].

35
36 The available findings suggest that self-assessment involves an interplay of factors that can be
37 complicated by lack of insight or of metacognitive skill, that is, ability to be self-observant in the
38 moment. Similarly, personal characteristics (e.g., gender, ethnicity, or cultural background) and the
39 impact of external factors (e.g., the purpose of self-assessment or whether it is designed to assess
40 practical skills or theoretical knowledge) can all affect self-assessment [12, 18]. The published
41 literature also indicates that interventions intended to enhance self-assessment may seek different
42 goals—improving the accuracy of self-assessors’ perception of their learning needs, promoting
43 appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

44
45 Self-assessment alone is not a reliable enough tool to ensure that physicians acquire and maintain
46 the competence they need to provide safe, high quality care. Feedback from third parties is
47 essential—or as one researcher has observed, “The road to self-knowledge may run through other
48 people” [19]. However, physicians are often wary of assessment. They have indicated that while
49 they want feedback, they are not sure how to use information that is not congruent with their self-
50 appraisals [20]. Physicians can be hesitant to seek feedback for fear of looking incompetent or
51 exposing possible deficiencies or out of concern that soliciting feedback could adversely affect

1 their relationships with those whom they approach [20]. They may also question the accuracy and
2 credibility of the assessment process and the data it generates [21].

3
4 To be effective, feedback must be valued by both those being assessed and those offering
5 assessment [14]. When there is tension between the stated goals of assessment and the implicit
6 culture of the health care organization or institution, assessment programs can too readily devolve
7 into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20].
8 Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews
9 (“360° reviews”), for example, are generally better suited to providing feedback on communication
10 and interpersonal skills than on technical knowledge or skills—and easy for evaluators to
11 understand and use [14]. High quality feedback will come from multiple sources; be specific and
12 focus on key elements of the ability being assessed; address behaviors rather than personality or
13 personal characteristics; and “provide both positive comments to reinforce good behavior and
14 constructive comments with action items to address deficiencies” [22].

15 16 EXPERTISE & EXPERT JUDGMENT

17
18 On this broad understanding of competence, physicians’ thought processes are as important as their
19 knowledge base or technical skills. Thus, understanding competence requires understanding
20 something of the nature of expertise and processes of expert reasoning, themselves topics of
21 ongoing exploration [23, 24, 25, 26]. Prevailing theory distinguishes “fast” from “slow” thinking;
22 that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate,
23 analytical processes that require more conscious effort [25]. Some scholars take expertise to
24 involve “fast” processes, and specifically decision making that involves automatic, nonanalytic
25 resources acquired through experience [23]. Others argue that expertise consists in using “slow,”
26 effortful, analytic processes to address problems [23]. A more integrative view argues that
27 expertise resides in being able to transition between intuitive and analytical processes as
28 circumstances require. On this account, experts use automatic resources to free up cognitive
29 capacity so that they maintain awareness of the environment (“situational awareness”) and can
30 determine when to shift to effortful processes [23].

31
32 Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s]
33 automatic resources and to transition appropriately to a greater reliance on effortful processes when
34 needed” [23], a practice described as “slowing down.” Knowing when to slow down and be
35 reflective has been demonstrated to improve diagnostic accuracy and other outcomes [25]. To
36 respond to the unexpected events that often arise in a clinical situation, the physician must
37 “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to
38 transition into a more effortful state [24]. This can happen, for example, when a surgeon confronts
39 an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should”
40 serves as a critical marker for intraoperative surgical judgment [23].

41 42 INFLUENCES ON CLINICAL REASONING

43
44 Clinical reasoning is a complex endeavor. Physicians’ capabilities develop through education,
45 training, and experiences that provide tools with which to shape their clinical reasoning. Every
46 physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or
47 differ from the analytical and investigative processes of their colleagues in innumerable ways.
48 When something goes wrong in the clinic, it can be difficult to discern why. Nonetheless, all
49 physicians are open to certain common pitfalls in reasoning, including relying unduly on heuristics
50 and habits of perception, and succumbing to overconfidence.

1 *Heuristics*

2
3 Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While
4 heuristics can be useful tools to help physicians identify and categorize relevant information, these
5 time-saving devices can also derail decision making. For example, a physician may mistakenly
6 assume that “something that seems similar to other things in a certain category is itself a member of
7 that category” (the representative heuristic) [27], and fail to diagnose a serious health problem.
8 Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that
9 the physician proceeds to discount as stress or intoxication once the physician learns that the
10 patient is going through a divorce or smells alcohol on the patient’s breath. Or a physician may
11 miscalculate the likelihood of a disease or injury occurring by placing too much weight “on
12 examples of things that come to mind easily, ... because they are easily remembered or recently
13 encountered” (the availability heuristic) [27]. For example, amidst heavy media coverage of an
14 outbreak of highly infectious disease thousands of miles away in a remote part of the world, a
15 physician seeing a patient with symptoms of what is actually a more commonplace illness may
16 misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

17
18 Clinical reasoning can be derailed by other common cognitive missteps as well. These can include
19 misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to
20 remember information transferred at the beginning (or end) of an exchange but not information
21 transferred in the middle (primary or recency bias) [25, 27, 29].

22 23 *Habits of Perception*

24
25 Like every other person, physicians can also find themselves prone to explicit (conscious) or
26 implicit (unconscious) habits of perception or biases. Physicians may allow unquestioned
27 assumptions based on a patient’s race or ethnicity, gender, socioeconomic status, or health
28 behavior, among other features, to shape how they perceive the patient and how they engage with,
29 evaluate and treat the individual. Basing one’s interactions with a patient on pre-existing
30 expectations or stereotypes demeans the patient, undermines the patient’s relationship with the
31 physician and the health care system, and can result in significant health disparities across entire
32 communities [30]. This is of particular concern for patients who are members of minority and
33 historically disadvantaged populations [30]. Physicians may fall victim to the tendency to seek out
34 information that confirms established expectations or dismiss contradicting information that does
35 not fit into predetermined beliefs (confirmatory bias) [27]. These often inadvertent thought
36 processes can result in a physician pursuing an incorrect line of questioning or testing that then
37 leads to a misdiagnosis or the wrong treatment.

38
39 No matter how well a patient may seem to fit a stereotype, it is imperative that the physician look
40 beyond categories and assumptions to investigate openly the health issues experienced by the
41 patient. Although all human beings exhibit both conscious and unconscious habits of perception,
42 physicians must remain vigilant in not allowing preconceived or unexamined assumptions to
43 influence their medical practice.

44 45 *Overconfidence*

46
47 Finally, another obstacle to strong clinical reasoning that physicians may encounter is
48 overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying
49 the gaps in their knowledge [27, 29]. Physicians may consider their skills to be excellent, when, in
50 fact, their peers have identified areas for improvement [29]. Overconfidence in one’s abilities can

1 lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the
2 advice of others, or not acknowledging one's limits [27, 29].

3
4 To avoid falling into such traps, physicians must recognize that many factors can and will influence
5 their clinical decisions [27]. They need to be aware of the information they do and do not have and
6 they need to acknowledge that many factors can and will influence their judgment. They should
7 keep in mind the likelihood of diseases and conditions and take the time to distinguish information
8 that is truly essential to sound clinical judgment from the wealth of possibly relevant information
9 available about a patient. They should consider reasons their decisions may be wrong and seek
10 alternatives, as well as seek to disprove rather than confirm their hypotheses [27]. And they should
11 be sensitive to the ways in which assumptions may color their reasoning and not allow expectations
12 to govern their interactions with patients.

13
14 Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming
15 aware of areas in which their skills are not at their strongest and seeking additional education or
16 consulting with colleagues, physicians can enhance their practice and best serve their patients.

17 FROM SELF-ASSESSMENT TO SELF-AWARENESS

18
19
20 Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally
21 conceived has significant shortcomings, several scholars have argued that a different understanding
22 of self-assessment is needed, along with a different conceptualization of its role in a self-regulating
23 profession [31]. Self-assessment, it is suggested, is a mechanism for identifying both one's
24 weaknesses and one's strengths. One should be aware of one's weaknesses in order to self-limit
25 practice in areas in which one has limited competence, to help set appropriate learning goals, and to
26 identify areas that "should be accepted as forever outside one's scope of competent practice" [31].
27 Knowing one's strengths, meanwhile, allows a physician both to "act with appropriate confidence"
28 and to "set appropriately challenging learning goals" that push the boundaries of the physician's
29 knowledge [31].

30
31 If self-assessment is to fulfill these functions, physicians need to reflect on past performance to
32 evaluate not only their general abilities but also specific completed performances. At the same
33 time, they must use self-assessment predictively to assess how likely they are to be able to manage
34 new challenges and new situations. More important, physicians should understand self-assessment
35 as an ongoing process of monitoring tasks during performance [32]. The ability to monitor oneself
36 in the moment is critical to physicians' ethical responsibility to practice safely, at the top of their
37 expertise but not beyond it.

38
39 Expert practitioners rely on pattern recognition and other automatic resources to be able to think
40 and act intuitively. As noted above, an important component of expert judgment is transitioning
41 effectively from automatic modes of thinking to more effortful modes as the situation requires.
42 Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts
43 physicians when they need to direct additional cognitive resources to the immediate task. For
44 example, among surgeons, knowing when to "slow down" during a procedure is critical to
45 competent professional performance, whether that means actually stopping the procedure,
46 withdrawing attention from the surrounding environment to focus more intently on the task at hand,
47 or removing distractions from the operating environment [24].

48
49 Physicians should also be sensitive to the ways that interruptions and distractions, which are
50 common in health care settings, can affect competence in the moment [33, 34], by disrupting
51 memory processes, particularly the "prospective memory" —i.e., "a memory performance in which

1 a person must recall an intention or plan in the future without an agent telling them to do so”—
2 important for resuming interrupted tasks [34, 35]. Systems-level interventions have been shown to
3 help reduce the number or type of interruptions and distractions and mitigate their impact on
4 medical errors [36].

5
6 A key aspect of competence is demonstrating situation-specific awareness in the moment of being
7 at the boundaries of one’s knowledge and responding accordingly [32]. Slowing down, looking
8 things up, consulting a colleague, or deferring from taking on a case can all be appropriate
9 responses when physicians’ self-awareness tells them they are at the limits of their abilities. The
10 capacity for ongoing, attentive self-observation, for “mindful” practice, is an essential marker of
11 competence broadly understood:

12
13 Safe practice in a health professional’s day-to-day performance requires an awareness of when
14 one lacks the specific knowledge or skill to make a good decision regarding a particular patient
15 ... This decision making in context is importantly different from being able to accurately rate
16 one’s own strengths and weaknesses in an acontextual manner.... Safe practice requires that
17 self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of
18 self-efficacy and ongoing ‘reflection-in-practice,’ addressing emergent problems and
19 continuously monitoring one’s ability to effectively solve the current problem [31].
20

21 Self-aware physicians discern when they are no longer comfortable handling a particular type of
22 case and know when they need to obtain more information or need additional resources to
23 supplement their own skills [31]. Self-aware physicians are also alert to how external stressors—
24 the death of a loved one or other family crisis, or the reorganization of their practice, for example—
25 may be affecting their ability to provide care appropriately at a given time. They recognize when
26 they should ask themselves whether they should postpone care, arrange to have a colleague provide
27 care, or otherwise find ways to protect the patient’s well-being.
28

29 MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

30
31 For physicians, the ideal is not simply to be “good” practitioners, but to excel throughout their
32 professional careers. This ideal holds not just over the course of a sustained clinical practice, but
33 equally when physicians re-enter practice after a hiatus, transition from active patient care to roles
34 as educators or administrators, or take on other functions in health care. Self-assessment and self-
35 awareness are central to achieving that goal.
36

37 A variety of strategies are available to physicians to support effective self-assessment and help
38 physicians cultivate the kind of self-awareness that enables them to “know when to slow down” in
39 day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in
40 the form of written descriptions, audio or video recording, or photos of encounters with patients
41 that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to
42 improve practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike
43 standardized examinations, they are drawn from one’s actual work and require self-reflection [15].
44

45 As noted above, to be effective, self-assessment must be joined with input from others. Well-
46 designed multi-source feedback can be useful in this regard, particularly for providing information
47 about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple
48 response that elicits feedback about how well one maintains trust and professional relationships
49 with patients, one’s communication and teamwork skills, and accessibility offers a valid, reliable
50 tool that can have practical value in helping to correct poor behavior and, just as important,

1 consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful
2 feedback will not have the rigor of a validated tool but can accomplish similar ends.

3
4 Reflective practice, that is, the habit of using critical reflection to learn from experience, is
5 essential to developing and maintaining competence across a physician's practice lifetime [37]. It
6 enables physicians to "integrate personal beliefs, attitudes, and values in the context of professional
7 culture," and to bridge new and existing knowledge. Studies suggest that reflective thinking can be
8 assessed, and that it can be developed, but also that the habit can be lost over time with increasing
9 years in practice [37].

10
11 "Mindful practice," that is, being fully present in everyday experience and aware of one's own
12 mental processes (including those that cloud decision making) [38], sustains the attitudes and skills
13 that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on
14 behavior over consciousness, erects barriers to mindful practice, while an individual's unexamined
15 negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can
16 be self-taught, but for most it is most effectively learned in relationship with a mentor or guide.
17 Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness.
18 Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of
19 encounters with patients, or seeking insight from critical incident reports [38].

20
21 "Exemplary physicians," one scholar notes, "seem to have a capacity for self-critical reflection that
22 pervades all aspects of practice, including being present with the patient, solving problems,
23 eliciting and transmitting information, making evidence-based decisions, performing technical
24 skills, and defining their own values" [38].

25 26 RECOMMENDATION

27
28 The Council on Ethical and Judicial Affairs recommends that the following be adopted and the
29 remainder of this report be filed:

30
31 The profession of medicine promises that throughout their careers practitioners will have the
32 knowledge, skills, and characteristics to practice safely and that the profession as a whole and
33 its individual members will hold themselves accountable to identify and address lapses.
34 Medical schools, residency and fellowship programs, specialty societies, and other health care
35 institutions regularly assess physicians' technical knowledge and skills.

36
37 However, the ethical responsibility of competence encompasses more than medical knowledge
38 and skill. It requires physicians to understand that as a practical matter in the care of actual
39 patients, competence is fluid and dependent on context. Importantly, the ethical responsibility
40 of competence requires that physicians at all stages of their professional lives be able to
41 recognize when they are and when they are not able to provide appropriate care for the patient
42 in front of them or the patients in their practice as a whole.

43
44 To fulfill the ethical responsibility of competence, individual physicians and physicians in
45 training should:

- 46
47 (a) Routinely exercise skills of self-awareness and active self-observation;
48
49 (b) Recognize that different points of transition in professional life can make different
50 demands on competence;

- 1 (c) Take advantage of tools for self-assessment appropriate to their practice settings and
2 patient populations;
3
4 (d) Regularly seek feedback from peers and others;
5
6 (e) Be attentive to environmental and other factors that may compromise their ability to bring
7 their best skills to the care of individual patients, immediately or over the longer term.
8
9 Medicine as a profession should continue to refine mechanisms to meaningfully assess
10 physician competence, including:
11
12 (f) Developing appropriate ways to assess knowledge and skills across the professional
13 lifecycle;
14
15 (g) Providing meaningful opportunity for physicians and physicians in training to hone their
16 ability to be self-reflective and attentive in the moment;
17
18 (h) Supporting efforts to develop more and better techniques to address gaps in knowledge,
19 skills, and self-awareness.
20
21 (New HOD Policy)

Fiscal Note: Less than \$500.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-16)

Introduced by: Medical Student Section

Subject: Support for the Decriminalization and Treatment of Suicide Attempts
Amongst Military Personnel

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

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- 1 Whereas, The Department of Defense Suicide Event Report states that in 2014, 269 active duty
2 service members took their own lives, and there were 1,126 suicide attempts;¹ and
3
4 Whereas, Article 134.103a of the Uniform Code of Military Justice (UCMJ) states that active
5 duty service members can be criminally charged for attempting suicide, regardless of supposed
6 intention to avoid duty;² and
7
8 Whereas, Punitive measures upon conviction after a suicide attempt include dishonorable
9 discharge, forfeiture of all pay and allowances, and confinement for up to 5 years;¹ and
10
11 Whereas, The policy for criminally charging “self injury without intent to avoid service” was
12 established in the Manuals of Court Martials of the U.S. Army in 1949 and added to the UCMJ
13 during its initiation in 1951, at a time when mental illness was not well understood;¹ and
14
15 Whereas, Punishing suicide attempt survivors goes against current recommendations and
16 Department of Defense progress to destigmatize mental illness and improve self-reported
17 care;^{3,4} and
18
19 Whereas, Existing AMA policy calls for awareness of suicide as a mental health issue
20 (D-345.994, H-60.937), and states that the AMA will use its influence to expedite quality medical
21 care, including mental health care, for all military personnel (D-510.996); therefore be it
22
23 RESOLVED, That our American Medical Association support efforts to decriminalize suicide
24 attempts in the military (New HOD Policy); and be it further
25
26 RESOLVED, That our AMA support efforts to provide treatment for survivors of suicide attempt
27 in lieu of punishment in the military. (New HOD Policy)

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

Received: 08/29/16

¹ Pruitt LD, Smolenski DJ, Reger MA, Bush NE, Skopp NA, Campise RL. Department of Defense Suicide Event Report (DoDSER): Calendar Year 2014 Annual Report: iv-v.

² UCMJ – United States Code of Military Justice. UCMJ United States Code of Military Justice RSS. Available at: https://www.loc.gov/rr/frd/Military_Law/pdf/MCM-2012.pdf. Accessed March 28, 2016.

³ Acosta, Joie, *et al.* Assessing the Department of Defense's Approach to Reducing Mental Health Stigma. Santa Monica, CA: RAND Corporation, 2016. Available at: http://www.rand.org/pubs/research_briefs/RB9881.html. Last Accessed: August 15, 2016.

⁴ Ramchand, Rajeev, *et al.* Suicide Postvention in the Department of Defense: Evidence, Policies and Procedures, and Perspectives of Loss Survivors. Santa Monica, CA: RAND Corporation, 2015. Available at: http://www.rand.org/pubs/research_reports/RR586.html. Last Accessed: August 15, 2016.

RELEVANT AMA POLICY

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

Citation: (Res. 412, A-06; Appended: Res. 907, I-12)

Teen and Young Adult Suicide in the United States H-60.937

Our AMA recognizes teen and young-adult suicide as a serious health concern in the US.

Citation: (Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

Military Care in the Public and Private Sector D-510.996

Our AMA will use its influence to expedite quality medical care, including mental health care, for all military personnel and their families by developing a national initiative and strategies to utilize civilian health care resources to complement the federal health care systems.

Citation: (Res. 444, A-07)

Support of Human Rights and Freedom H-65.965

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

Citation: (CCB/CLRPD Rep. 3, A-14)

Teen and Young Adult Suicide in the United States H-60.937

Our AMA recognizes teen and young-adult suicide as a serious health concern in the US.

Citation: (Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15)

Supporting Awareness of Stress Disorders in Military Members and Their Families H-510.988

Our AMA supports efforts to educate physicians and supports treatment and diagnosis of stress disorders in military members, veterans and affected families and continue to focus attention and raise awareness of this condition in partnership with the Department of Defense and the Department of Veterans Affairs.

Citation: (Sub. Res. 401, A-10)

Health Care for Veterans and Their Families D-510.994

Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.

Citation: (BOT Rep. 6, A-08; Reaffirmed: Sub. Res. 709, A-15)

Military Care in the Public and Private Sector D-510.996

Our AMA will use its influence to expedite quality medical care, including mental health care, for all military personnel and their families by developing a national initiative and strategies to utilize civilian health care resources to complement the federal health care systems.

Citation: (Res. 444, A-07)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(I-16)

Introduced by: Medical Student Section

Subject: Living Organ Donation at the Time of Imminent Death

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

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- 1 Whereas, Patients who receive organs procured from living donors have better outcomes than
2 those who receive organs from deceased donors;^{1,2,3} and
3
4 Whereas, The kidney is the most commonly transplanted organ from a living donor; in rare
5 cases, a segment of organs such as lung, intestine, or pancreas can be transplanted from a
6 living donor;⁴ and
7
8 Whereas, The ethics of organ transplantation have been premised on “the dead donor rule”
9 (DDR), which states that vital organs should be taken only from persons who are dead;⁵ and
10
11 Whereas, It is unclear why certain living patients, such as those who are near death but on life
12 support, should not be allowed to donate their organs, if doing so would benefit others and be
13 consistent with their own interests;⁵ and
14
15 Whereas, AMA Ethical Opinion 6.1.1 states, “Donation of nonvital organs and tissue from living
16 donors can increase the supply of organs available for transplantation, to the benefit of patients
17 with end-stage organ failure and enabling individuals to donate nonvital organs is in keeping
18 with the goals of treating illness and relieving suffering so long as the benefits to both donor and
19 recipient outweigh the risks to both;” therefore be it
20
21 **RESOLVED**, That our American Medical Association study the implications of the removal of
22 barriers to living organ donation at the time of imminent death. (Directive to Take Action)

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

Received: 09/29/16

¹ Mezrich J, Scalea J. As They Lay Dying. The Atlantic, 2015.

² Meier-Kriesche HU, Kaplan B. Waiting time on dialysis as the strongest modifiable risk factor for renal transplant outcomes: a paired donor kidney analysis. Transplantation. 2002;74: 1377-1381.

³ Davis CL, Delmonico FL. Living-donor kidney transplantation: a review of the current practices for the live donor. J Am Soc Nephrol. 2005;16: 2098-2110.

⁴The United Network for Organ Sharing, Types of Living Donor Transplants. Available at: <https://www.unos.org/donation/living-donation/> . Last Accessed: August 11, 2016.

⁵ Robert D. Truog, M.D., Franklin G. Miller, Ph.D., and Scott D. Halpern, M.D., Ph.D., The Dead Donor Rule and the Future of Organ Donation, N Engl J Med 2013; 369:1287-1289. Available at: <http://www.nejm.org/doi/full/10.1056/NEJMp1307220#t=article>. Last Accessed: August 11, 2016.

RELEVANT AMA POLICY

Methods to Increase the US Organ Donor Pool H-370.959 - In order to encourage increased levels of organ donation in the United States, our American Medical Association: (1) supports studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urges development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs; and (3) encourages continued study of ways to enhance the allocation of donated organs and tissues. BOT Rep. 13, A-15

UNOS Kidney Paired Donation Program H-370.960 - Our AMA: (1) encourages the continued expansion of the United Network for Organ Sharing's (UNOS) Kidney Paired Donation program which provides a national registry of living donors, carries out ongoing data collection on key issues of concern in transplantation from living donors, and through its operational guidelines provides consistent, national standards for the transplant community; and (2) encourages voluntary coordination among private donor registries and UNOS to enhance the availability of organs for transplantation. BOT Action in response to referred for decision Res. 2, A-13

Removing Financial Barriers to Living Organ Donation H-370.965 - Our AMA supports federal and state laws that remove financial barriers to living organ donation, such as: (1) provisions for expenses involved in the donation incurred by the organ donor, (2) providing access to health care coverage for any medical expense related to the donation, (3) prohibiting employment discrimination on the basis of living donor status, and (4) prohibiting the use of living donor status as the sole basis for denying health and life insurance coverage. BOT Rep. 15, A-12

Organ Donation D-370.985 - Our AMA will study potential models for increasing the United States organ donor pool. Res. 1, A-14 Reaffirmed in lieu of Res. 5, I-14

Surrogate Consent for Living Organ Donation H-370.964 - Our AMA opposes the practice of surrogate consent for living organ donation from patients in a persistent vegetative state. Res. 7, A-12

Ethical Procurement of Organs for Transplantation H-370.967 - Our AMA will continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary. BOT Rep. 13, A-08

Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982 - Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered. (2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All

candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula. (3) Decisionmaking mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions. (4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision. (5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession. (6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them. (7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means. CEJA Rep. K, A-93 Reaffirmed: CSA Rep. 12, I-99 Reaffirmed: CSA Rep. 6, A-00 Appended: Res. 512, A-02 Reaffirmed: CEJA Rep. 3, A-12

Ethical Issues in the Procurement of Organs Following Cardiac Death H-370.975 - The Pittsburgh Protocol: The following guidelines have been adopted: The Pittsburgh protocol, in which organs are removed for transplantation from patients who have had life-sustaining treatment withdrawn, may be ethically acceptable and should be pursued as a pilot project. The pilot project should (1) determine the protocol's acceptability to the public, and (2) identify the number and usability of organs that may be procured through this approach. The protocol currently has provisions for limiting conflicts of interest and ensuring voluntary consent. It is critical that the health care team's conflict of interest in caring for potential donors at the end of life be minimized, as the protocol currently provides, through maintaining the separation of providers caring for the patient at the end of life and providers responsible for organ transplantation. In addition to the provisions currently contained in the protocol, the following additional safeguards are recommended: (a) To protect against undue conflicts of interest, the protocol should explicitly warn members of the health care team to be sensitive to the possibility that organ donation decisions may influence life-sustaining treatment decisions when the decisions are made by surrogates. Further, if there is some reason to suspect undue influence, then the health care team members should be required, not merely encouraged, to obtain a full ethics consultation. (b) The recipients of organs procured under the Pittsburgh protocol should be informed of the source of the organs as well as any potential defects in the quality of the organs, so that they may decide with their physicians whether to accept the organs or wait for more suitable ones. (c) Clear clinical criteria should be developed to ensure that only appropriate candidates, whose organs are reasonably likely to be suitable for transplantation, are considered eligible to donate organs under the Pittsburgh protocol. CEJA Rep. 4 - I-94 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CEJA Rep. 3, A-12

Transplantable Organs as a National Resource H-370.990 - Our AMA: (1) supports the United Network of Organ Sharing (UNOS) policy calling for regional allocation of livers to status 1 (most urgent medical need) patients as an effort to more equitably distribute a scarce resource; (2) opposes any legislation, regulations, protocols, or policies directing or allowing

governmental agencies to favor residents of a particular geo-political jurisdiction as recipients of transplantable organs or tissues; (3) reaffirms its position that organs and tissues retrieved for transplantation should be treated as a national, rather than a regional, resource; and (4) supports the findings and recommendations of the Institute of Medicine Committee on Organ Procurement and Transplantation Policy. Res. 94, I-87 Reaffirmed: Sunset Report, I-97 Appended and Reaffirmed CSA Rep. 12, I-99 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12

Organ Donor Recruitment H-370.995 - Our AMA supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following: (1) the need for organ donors;(2) the success rate for organ transplantation;(3) the medico-legal aspects of organ transplantation; (4) the integration of organ recruitment, preservation and transplantation; (5) cost/reimbursement mechanisms for organ transplantation; and(6) the ethical considerations of organ donor recruitment. Res. 32, A-82 Reaffirmed: CLRPD Rep. A, I-92 Reaffirmed: CSA Rep. 6, A-00 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12

Organ Donor Recruitment H-370.996 - Our AMA (1) continues to urge Americans to sign donor cards; (2) supports continued efforts to teach physicians through continuing medical education courses, and the lay public through health education programs, about transplantation issues in general and the importance of organ donation in particular; (3) encourages state governments to attempt pilot studies on promotional efforts that stimulate each adult to respond "yes" or "no" to the option of signing a donor card.; and (4) in collaboration with all other interested parties, support the exploration of methods to greatly increase organ donation, such as the "presumed consent" modality of organ donation. CSA Rep. D, A-81 Reaffirmed: CLRPD Rep. F, I-91 Appended: Res. 509, I-98 Reaffirmed: CSA Rep. 6, A-00 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12

Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962 - Our AMA supports federal funding of organ transplants for Medicaid patients. BOT Rep. 15, A-13

Tissue and Organ Donation H-370.983 - Our AMA will assist the United Network for Organ Sharing in the implementation of their recommendations through broad-based physician and patient education. Res. 533, A-92 Reaffirmed: CSA Rep. 12, I-99 Reaffirmed: CSA Rep. 6, A-00 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12

Donor Tissues and Organs for Transplantation H-370.986 - The AMA strongly urges physicians or their designees to routinely contact their hospital's designated tissue or organ procurement agency (as appropriate), at or near the time of each patient's death, to determine the feasibility of tissue and/or organ donation. Res. 103, I-90 Reaffirmed: CSA Rep. 6, A-00 Reaffirmed: CSA Rep. 4, I-02 Reaffirmed: CSAPH Rep. 1, A-12

The Physician's Role in Organ Donation D-370.997 - Our AMA will continue to promote organ donation awareness. CSA Rep. 6, A-00 Modified: CSAPH Rep. 1, A-10

Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool H-370.958 - 1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation. 2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates.

3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation. Res. 7, I-15

6.1.1 Transplantation of Organs from Living Donors

Donation of nonvital organs and tissue from living donors can increase the supply of organs available for transplantation, to the benefit of patients with end-stage organ failure. Enabling individuals to donate nonvital organs is in keeping with the goals of treating illness and relieving suffering so long as the benefits to both donor and recipient outweigh the risks to both.

Living donors expose themselves to harm to benefit others; novel variants of living organ donation call for special safeguards for both donors and recipients.

Physicians who participate in donation of nonvital organs and tissues by a living individual should:

- (a) Ensure that the prospective donor is assigned an advocacy team, including a physician, dedicated to protecting the donor's well-being.
- (b) Avoid conflicts of interest by ensuring that the health care team treating the prospective donor is as independent as possible from the health care team treating the prospective transplant recipient.
- (c) Carefully evaluate prospective donors to identify serious risks to the individual's life or health, including psychosocial factors that would disqualify the individual from donating; address the individual's specific needs; and explore the individual's motivations to donate.
- (d) Secure agreement from all parties to the prospective donation in advance so that, should the donor withdraw, his or her reasons for doing so will be kept confidential.
- (e) Determine that the prospective living donor has decision-making capacity and adequately understands the implications of donating a nonvital organ, and that the decision to donate is voluntary.
- (f) In general, decline proposed living organ donations from unemancipated minors or legally incompetent adults, who are not able to understand the implications of a living donation or give voluntary consent to donation.
- (g) In exceptional circumstances, enable donation of a nonvital organ or tissue from a minor who has substantial decision-making capacity when:
 - (i) the minor agrees to the donation;
 - (ii) the minor's legal guardians consent to the donation;
 - (iii) the intended recipient is someone to whom the minor has an emotional connection.
- (h) Seek advice from another adult trusted by the prospective minor donor when circumstances warrant, or from an independent body such as an ethics committee, pastoral service, or other institutional resource.
 - (i) Inform the prospective donor:
 - (i) about the donation procedure and possible risks and complications for the donor;
 - (ii) about the possible risks and complications for the transplant recipient;
 - (iii) about the nature of the commitment the donor is making and the implications for other parties;
 - (iv) that the prospective donor may withdraw at any time before undergoing the intervention to remove the organ or collect tissue, whether the context is paired, domino, or chain donation; and
 - (v) that if the donor withdraws, the health care team will report simply that the individual was not a suitable candidate for donation.
 - (j) Obtain the prospective donor's separate consent for donation and for the specific intervention(s) to remove the organ or collect tissue.

- (k) Ensure that living donors do not receive payment of any kind for any of their solid organs. Donors should be compensated fairly for the expenses of travel, lodging, meals, lost wages, and medical care associated with the donation only.
- (l) Permit living donors to designate a recipient, whether related to the donor or not.
- (m) Decline to facilitate a living donation to a known recipient if the transplantation cannot reasonably be expected to yield the intended clinical benefit or achieve agreed on goals for the intended recipient.
- (n) Permit living donors to designate a stranger as the intended recipient if doing so produces a net gain in the organ pool without unreasonably disadvantaging others on the waiting list. Variations on donation to a stranger include:
 - (i) prospective donors who respond to public solicitations for organs or who wish to participate in a paired donation (“organ swap,” as when donor-recipient pairs Y and Z with incompatible blood types are recombined to make compatible pairs: donor-Y with recipient-Z and donor-Z with recipient-Y);
 - (ii) domino paired donation;
 - (iii) nonsimultaneous extended altruistic donation (“chain donation”).
- (o) When the living donor does not designate a recipient, allocate organs according to the algorithm that governs the distribution of deceased donor organs.
- (p) Protect the privacy and confidentiality of donors and recipients, which may be difficult in novel donation arrangements that involve many patients and in which donation-transplant cycles may be extended over time (as in domino or chain donation).
- (q) Monitor prospective donors and recipients in proposed nontraditional donation arrangements for signs of psychological distress during screening and after the transplant is complete.
- (r) Support the development and maintenance of a national database of living donor outcomes to support better understanding of associated harms and benefits and enhance the safety of living donation.

AMA Principles of Medical Ethics: I, V, VII, VIII

6.1.3 Studying Financial Incentives for Cadaveric Organ Donation

Physicians’ ethical obligations to contribute to the health of the public and to support access to medical care extend to participating in efforts to increase the supply of organs for transplantation. However, offering financial incentives for donation raises ethical concerns about potential coercion, the voluntariness of decisions to donate, and possible adverse consequences, including reducing the rate of altruistic organ donation and unduly encouraging perception of the human body as a source of profit.

These concerns merit further study to determine whether, overall, the benefits of financial incentives for organ donation outweigh their potential harms. It would be appropriate to carry out pilot studies among limited populations to investigate the effects of such financial incentives for the purpose of examining and possibly revising current policies in the light of scientific evidence. Physicians who develop or participate in pilot studies of financial incentives to increase donation of cadaveric organs should ensure that the study:

- (a) Is strictly limited to circumstances of voluntary cadaveric donation with an explicit prohibition of the selling of organs.
- (b) Is scientifically well designed and clearly defines measurable outcomes and time frames in a written protocol.
- (c) Has been developed in consultation with the population among whom it is to be carried out.

- (d) Has been reviewed and approved by an appropriate oversight body, such as an institutional review board, and is carried out in keeping with guidelines for ethical research.
- (e) Offers incentives of only modest value and at the lowest level that can reasonably be expected to increase organ donation.

AMA Principles of Medical Ethics: I,III,V,VII,VIII,IX

6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors

Organ transplantation offers hope for patients suffering end-stage organ failure. However, the supply of organs for transplantation is inadequate to meet the clinical need. Proposals to increase donation have included studying possible financial incentives for donation and changing the approach to consent for cadaveric donation through “presumed consent” and “mandated choice.”

Both presumed consent and mandated choice models contrast with the prevailing traditional model of voluntary consent to donation, in which prospective donors indicate their preferences, but the models raise distinct ethical concerns. Under presumed consent, deceased individuals are presumed to be organ donors unless they have indicated their refusal to donate. Donations under presumed consent would be ethically appropriate only if it could be determined that individuals were aware of the presumption that they were willing to donate organs and if effective and easily accessible mechanisms for documenting and honoring refusals to donate had been established. Physicians could proceed with organ procurement based on presumed consent only after verifying that there was no documented prior refusal and that the family was not aware of any objection to donation by the deceased.

Under mandated choice, individuals are required to express their preferences regarding donation at the time they execute a state-regulated task. Donations under mandated choice would be ethically appropriate only if an individual’s choice was made on the basis of a meaningful exchange of information about organ donation in keeping with the principles of informed consent. Physicians could proceed with organ procurement based on mandated choice only after verifying that the individual’s consent to donate was documented.

These models merit further study to determine whether either or both can be implemented in a way that meets fundamental ethical criteria for informed consent and provides clear evidence that their benefits outweigh ethical concerns.

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

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

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

AMA Principles of Medical Ethics: I,III,V

6.2.1 Guidelines for Organ Transplantation from Deceased Donors

Transplantation offers hope to patients with organ failure. As in all patient-physician relationships, the physician’s primary concern must be the well-being of the patient. However, organ transplantation is also unique in that it involves two patients, donor and recipient, both of whose interests must be protected. Concern for the patient should always take precedence over advancing scientific knowledge.

Physicians who participate in transplantation of organs from deceased donors should:

- (a) Avoid actual or perceived conflicts of interest by ensuring that:
 - (i) to the greatest extent possible that the health care professionals who provide care at the end of life are not directly involved in retrieving or transplanting organs from the deceased donor. Physicians should encourage health care institutions to distinguish the roles of health care professionals who solicit or coordinate organ transplantation from those who provide care at the time of death;
 - (ii) no member of the transplant team has any role in the decision to withdraw treatment or the pronouncement of death.
- (b) Ensure that death is determined by a physician not associated with the transplant team and in accordance with accepted clinical and ethical standards.
- (c) Ensure that transplant procedures are undertaken only by physicians who have the requisite medical knowledge and expertise and are carried out in adequately equipped medical facilities.
- (d) Ensure that the prospective recipient (or the recipient's authorized surrogate if the individual lacks decision-making capacity) is fully informed about the procedure and has given voluntary consent in keeping with ethical guidelines.
- (e) Except in situations of directed donation, ensure that organs for transplantation are allocated to recipients on the basis of ethically sound criteria, including but not limited to likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in certain cases, amount of resources required for successful treatment.
- (f) Ensure that organs for transplantation are treated as a national, rather than a local or regional, resource.
- (g) Refrain from placing transplant candidates on the waiting lists of multiple local transplant centers, but rather place candidates on a single waiting list for each type of organ.

AMA Principles of Medical Ethics: I,III,V

6.2.2 Directed Donation of Organs for Transplantation

Efforts to increase the supply of organs available for transplant can serve the interests of individual patients and the public and are in keeping with physicians' obligations to promote the welfare of their patients and to support access to care. Although public solicitations for directed donation—that is, for donation to a specific patient—may benefit individual patients, such solicitations have the potential to adversely affect the equitable distribution of organs among patients in need, the efficacy of the transplant system, and trust in the overall system.

Donation of needed organs to specified recipients has long been permitted in organ transplantation. However, solicitation of organs from potential donors who have no pre-existing relationship with the intended recipient remains controversial. Directed donation policies that produce a net gain of organs for transplantation and do not unreasonably disadvantage other transplant candidates are ethically acceptable.

Physicians who participate in soliciting directed donation of organs for transplantation on behalf of their patients should:

- (a) Support ongoing collection of empirical data to monitor the effects of solicitation of directed donations on the availability of organs for transplantation.
- (b) Support the development of evidence-based policies for solicitation of directed donation.
- (c) Ensure that solicitations do not include potentially coercive inducements. Donors should receive no payment beyond reimbursement for travel, lodging, lost wages, and the medical care associated with donation.

(d) Ensure that prospective donors are fully evaluated for medical and psychosocial suitability by health care professionals who are not part of the transplant team, regardless of any relationship, or lack of relationship, between prospective donor and transplant candidate.

(e) Refuse to participate in any transplant that he or she believes to be ethically improper and respect the decisions of other health care professionals should they choose not to participate on ethical or moral grounds.

AMA Principles of Medical Ethics: VII, VIII, IX

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-16)

Introduced by: Medical Student Section

Subject: Study of the Current Uses and Ethical Implications of Expanded Access Programs

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 Whereas, Expanded access refers to the use of an investigational drug when the primary
2 purpose is to diagnose, monitor, or treat a patient rather than to obtain the kind of information
3 about the drug that is generally derived from clinical trials;¹ and
4

5 Whereas, The FDA's Expanded Access program requires that "the patient's physician determine
6 that there is no comparable or satisfactory alternative therapy available to diagnose, monitor, or
7 treat the person's disease or condition, and that the probable risk to the person from the
8 investigational product is not greater than the probable risk from the disease or condition";¹ and
9

10 Whereas, Recent state legislation colloquially known as "Right-to-Try" laws, allows terminally ill
11 patients access to investigational drugs that have passed phase 1 safety testing without FDA
12 authorization;^{2,3,4} and
13

14 Whereas, "Right-to-Try" laws vary state to state, but basic requirements include that the patient
15 with a terminal illness has considered alternative treatments that are currently available,
16 received a prescription from their physician for an experimental, unapproved medical product,
17 and provided written informed consent to undertake the risks inherent in utilizing the
18 experimental treatment;⁷ and
19

20 Whereas, The FDA Expanded Access program and Right-to-Try laws have significant potential
21 for misuse or unintended consequences including but not limited to offering patients false hope,
22 adverse reactions to the drug, financial burdens, setbacks to clinical drug development, and
23 unfair or biased decisions of approval for drug use;^{3,5,6} and
24

25 Whereas, A recurring argument in support of "Right-to-Try" laws is increased patient autonomy,
26 namely that patients with serious conditions ought to be able to make their own decisions
27 regarding their experimental treatment;⁶ therefore be it

¹ DHHS, FDA, CDER, CBER, Expanded Access to Investigational Drugs for Treatment Use – Questions and Answers, Guidance for Industry. June 2016. Available at:

<http://www.fda.gov/downloads/drugs/guidancecomplianceregulatoryinformation/guidances/ucm351261.pdf>

² 'Right to try' law gives terminal patients access to drugs not approved by FDA. PBS. 2014. <http://www.pbs.org/newshour/bb/right-try-law-gives-terminal-patients-access-non-fda-approved-drugs/>. Accessed April 8, 2016.

³ Leonard K. Seeking the Right to Try. US News & World Report. 2014. <http://www.usnews.com/news/articles/2014/11/18/right-to-try-laws-allowing-patients-to-try-experimental-drugs-bypass-fda>.

⁴ Jacob JA. Questions of Safety and Fairness Raised as Right-to-Try Movement Gains Steam. JAMA. 2015;314(8):758–760. doi:10.1001/jama.2015.7691.

⁵ Right-to-Try Laws. Health Affairs. 2015. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=135. Accessed April 10, 2016.

⁶ Hamel MB, Darrow JJ, Sarpatwari A, Avorn J, Kesselheim AS. Practical, Legal, and Ethical Issues in Expanded Access to Investigational Drugs. New England Journal of Medicine. 2015;372(3):279–286. doi:10.1056/nejmhle1409465.

1 RESOLVED, That our American Medical Association study the implementation of expanded
2 access programs, accelerated approval mechanisms, and payment reform models meant to
3 increase access of experimental therapies (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA study the ethics of expanded access programs, accelerated
6 approval mechanisms, and payment reform models meant to increase access of experimental
7 therapies. (Directive to Take Action)

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

Received: 09/29/16

RELEVANT AMA POLICY

Cannabis for Medicinal Use H-95.952 - (1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. CSA Rep. 10, I-97 Modified: CSA Rep. 6, A-01 Modified: CSAPH Rep. 3, I-09 Modified in lieu of Res. 902, I-10 Reaffirmed in lieu of Res. 523, A-11 Reaffirmed in lieu of Res. 202, I-12 Reaffirmed: CSAPH Rep. 2, I-13

Uniform Definition of Experimental Procedures and Therapies H-185.991 - The AMA supports working with the Health Insurance Association of America, the Blue Cross and Blue Shield Association, and other appropriate parties and federal agencies to develop uniform definitions for investigational or experimental therapies and procedures, so that methodologies can be established so that all who inquire may learn the status of a therapy or procedure. Res. 143, A-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CMS Rep. 4, A-08

Inclusion of Women in Clinical Trials H-525.991 - Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; (2) supports the National

Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and (3) encourages translation of important research results into practice. Res. 183, I-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CSAPH Rep. 1, A-10 Modified: CSAPH Rep. 05, A-16

7.1.3 Study Design & Sampling

To be ethically justifiable, biomedical and health research that involves human subjects must uphold fundamental principles of respect for persons, beneficence, and justice. These principles apply not only to the conduct of research, but equally to the selection of research topics and study design.

Well-designed, ethically sound research aligns with the goals of medicine, addresses questions relevant to the population among whom the study will be carried out, balances the potential for benefit against the potential for harm, employs study designs that will yield scientifically valid and significant data, and generates useful knowledge. For example, research to develop biological or chemical weapons is antithetical to the goals of the medical profession, whereas research to develop defenses against such weapons can be ethically justifiable.

Physicians who engage in biomedical or health research with human participants thus have an ethical obligation to ensure that any study with which they are involved:

- (a) Is consistent with the goals and fundamental values of the medical profession.
- (b) Addresses research question(s) that will contribute meaningfully to medical knowledge and practice.
- (c) Is scientifically well designed to yield valid data to answer the research question(s), including using appropriate population and sampling controls, clear and appropriate inclusion/exclusion criteria, a statistically sound plan for data collection and analysis, appropriate controls, and when applicable, criteria for discontinuing the study (stopping rules).
- (d) Minimizes risks to participants, including risks associated with recruitment and data collection activities, without compromising scientific integrity.
- (e) Provides mechanisms to safeguard confidentiality.
- (f) Does not disproportionately recruit participants from historically disadvantaged populations or populations whose ability to provide fully voluntary consent is compromised. Participants who otherwise meet inclusion/exclusion criteria should be recruited without regard to race, ethnicity, gender, or economic status.
- (g) Recruits participants who lack the capacity to give informed consent only when the study stands to benefit that class of participants and participants with capacity would not yield valid results. In this event, assent should be sought from the participant and consent should be obtained from the prospective participant's legally authorized representative, in keeping with ethical guidelines.
- (h) Has been reviewed and approved by appropriate oversight bodies.

AMA Principles of Medical Ethics: I, II, III, V, VII

7.1.1 Physician Involvement in Research

Biomedical and health research is intended to contribute to the advancement of knowledge and the welfare of society and future patients, rather than to the specific benefit of the individuals who participate as research subjects.

However, research involving human participants should be conducted in a manner that minimizes risks and avoids unnecessary suffering. Because research depends on the willingness of participants to accept risk, they must be able to make informed decisions about whether to participate or continue in a given protocol.

Physician researchers share their responsibility for the ethical conduct of research with the institution that carries out research. Institutions have an obligation to oversee the design, conduct, and dissemination of research to ensure that scientific, ethical, and legal standards are upheld. Institutional review boards (IRBs) as well as individual investigators should ensure that each participant has been appropriately informed and has given voluntary consent.

Physicians who are involved in any role in research with human participants have an ethical obligation to ensure that participants' interests are protected and to safeguard participants' welfare, safety, and comfort.

To fulfill these obligations, individually, physicians who are involved in research should:

- (a) Participate only in those studies for which they have relevant expertise.
- (b) Ensure that voluntary consent has been obtained from each participant or from the participant's legally authorized representative if the participant lacks the capacity to consent, in keeping with ethical guidelines. This requires that:
 - (i) prospective participants receive the information they need to make well-considered decisions, including informing them about the nature of the research and potential harms involved;
 - (ii) physicians make all reasonable efforts to ensure that participants understand the research is not intended to benefit them individually;
 - (iii) physicians also make clear that the individual may refuse to participate or may withdraw from the protocol at any time.
- (c) Assure themselves that the research protocol is scientifically sound and meets ethical guidelines for research with human participants. Informed consent can never be invoked to justify an unethical study design.
- (d) Demonstrate the same care and concern for the well-being of research participants that they would for patients to whom they provide clinical care in a therapeutic relationship. Physician researchers should advocate for access to experimental interventions that have proven effectiveness for patients.
- (e) Be mindful of conflicts of interest and assure themselves that appropriate safeguards are in place to protect the integrity of the research and the welfare of human participants.
- (f) Adhere to rigorous scientific and ethical standards in conducting, supervising, and disseminating results of the research.

AMA Principles of Medical Ethics: I, II, III, V

7.3.1 Ethical Use of Placebo Controls in Research

A fundamental requirement of biomedical and health research is that it must provide scientifically valid data. In some research, this can best be achieved by comparing an intervention against a control to identify the effects of the intervention. Used appropriately, a placebo control can provide valuable data, particularly when there is no accepted therapy for the condition under study.

The existence of an accepted therapy does not necessarily preclude use of placebo controls, but because use of a placebo deprives participants in the control arm of access to accepted therapy for some period of time, it requires thoughtful ethical justification. In general, the use of a placebo control will more easily be justified as the severity and number of negative side effects of standard therapy increase.

To ensure that the interests of human participants are protected, physician-researchers and those who serve on oversight bodies should give careful attention to issues of methodological rigor, informed consent, characteristics of the medical condition under study, and safety and monitoring, in keeping with the following guidelines:

- (a) Evaluate each study protocol to determine whether a placebo control is scientifically necessary or an alternative study design using a different type of control would be sufficient for the purposes of the research. Placebo controls are ethically justifiable when no other research design will yield the requisite data.
- (b) Assess the use of placebo controls in relation to the characteristics of the condition under study in keeping with the following considerations:
- (i) Studies that involve conditions likely to cause death or irreversible damage cannot ethically employ placebo controls if an alternative therapy would prevent or slow the progression of illness;
 - (ii) Studies that involve illnesses characterized by severe or painful symptoms require a thorough exploration of alternatives to the use of a placebo control;
 - (iii) In general, the more severe the consequences or symptoms of the illness under study, the more difficult it will be to justify the use of a placebo control when alternative therapy exists. Consequently, there will almost certainly be conditions for which placebo controls cannot ethically be justified.
- (c) Design studies to minimize the amount of time participants are on placebo without compromising the scientific integrity of the study or the value of study data.
- (d) Pay particular attention to the informed consent process when enrolling participants in research that uses a placebo control. In addition to general guidelines for informed consent in research, physician-researchers (or other health care professionals) who obtain informed consent from prospective subjects should:
- (i) describe the differences among the research arms, emphasizing the essential intervention(s) that will or will not be performed in each;
 - (ii) be sensitive to the possible need for additional safeguards in the consent process, such as having a neutral third party obtain consent or using a consent monitor to oversee the consent process.
- (e) Ensure that interim data analysis and monitoring are in place to allow researchers to terminate a study because of either positive or negative results, thus protecting participants from remaining on placebo longer than needed to ensure the scientific integrity of the study.
- (f) Avoid using surgical placebo controls—i.e., a control arm in which participants undergo surgical procedures that have the appearance of therapeutic interventions but during which the essential therapeutic maneuver is not performed—when there is a standard treatment that is efficacious and acceptable to the patient and forgoing standard treatment would result in significant injury. In these situations, physician-researchers must offer standard treatment as part of the study design. Use of surgical placebo controls may be justified when:
- (i) an existing, accepted surgical procedure is being tested for efficacy. Use of a placebo control is not justified to test the effectiveness of an innovative surgical technique that represents only a minor modification of an existing, accepted surgical procedure;
 - (ii) a new surgical procedure is developed with the prospect of treating a condition for which there is no known surgical therapy. In such cases, the use of placebo must be evaluated in light of whether the current standard of care includes a nonsurgical treatment and the risks, benefits, and side effects of that treatment;
 - (iii) the standard (nonsurgical) treatment is not efficacious or not acceptable to the patient;
 - (iv) Additional safeguards are in place in the informed consent process.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-16)

Introduced by: Medical Student Section

Subject: Addressing Patient Spirituality in Medicine

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

1 Whereas, In 2010, The Joint Commission decreed that health care providers should "ask
2 patients and families about staff responsiveness to their cultural, religious, and spiritual needs
3 during care planning and treatment";¹ and
4

5 Whereas, In a study of 3,141 patients, 41% of patients desired a discussion of religious and
6 spiritual concerns while hospitalized, but only half of those reported having such a discussion;²
7 and
8

9 Whereas, According to the same study, "patients who had discussions of their religious and
10 spiritual concerns were more likely to rate their care at the highest level on four different
11 measures of patient satisfaction, regardless of whether or not they had desired such a
12 discussion";² and
13

14 Whereas, Another prospective study of 339 patients with advanced cancer concluded that end-
15 of-life costs were higher when the spiritual needs of patients were not supported by the
16 healthcare team, especially among minorities and patients with higher religious coping;³ and
17

18 Whereas, A focal issue with practicing spirituality in medicine was that "the clinical environment
19 did not support the inclusion of a spiritual dimension in an assessment and treatment of spiritual
20 issues... and spiritual care was neglected in favor of physical care" in addition to perceived
21 degree of "antagonism towards assessing spirituality during their placement in clinical settings";⁴
22 and
23

24 Whereas, According to a national study by Duke University, 90% of medical school deans
25 indicated that patients stress spirituality in their healthcare and 90% reported that their school
26 had courses or content on spirituality and health;⁵ therefore be it
27

28 **RESOLVED**, That our American Medical Association support inquiry into, as well as discussion
29 and consideration of, individual patient spirituality as an important component of health (New
30 HOD Policy); and be it further

¹ The Joint Commission. Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals. Oakbrook Terrace, Ill.: The Joint Commission; 2011.

² Williams, J. A., Meltzer, D., Arora, V., et al. Attention to inpatients' religious and spiritual concerns: predictors and association with patient satisfaction. J Gen Intern Med. 2011; 26(11): 1265-1271.

³ Balboni T, Balboni M, Paulk ME, et al. Support of cancer patients' spiritual needs and associations with medical care costs at end of life. Cancer. 2011;117:5383-91.

⁴ Paal P, Helo Y, Frick E. Spiritual care training provided to healthcare professionals: A systematic review. J Pastoral Care Counsel. 2015. 69(1):19-30.

⁵ Koenig, H., Hooten, E., Lindsay-Calkins, E., et al. Spirituality in Medical School Curricula: Findings from a National Survey. Int J Psychiat Med. 2010; 391-398.

- 1 RESOLVED, That our AMA encourage expanded patient access to spiritual care services and
2 resources beyond trained healthcare professionals. (New HOD Policy)

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

Received: 09/29/16

RELEVANT AMA POLICY

Good Palliative Care H-70.915 - Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter.

CCB/CLRPD Rep. 3, A-14

Support of Human Rights and Freedom H-65.965 - Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

CCB/CLRPD Rep. 3, A-14

Symptomatic and Supportive Care for Patients with Cancer H-55.999 - Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.

CSA Rep. H, I-78 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00

Reaffirmed: Sub. Res. 514, I-00 Modified: CSAPH Rep. 1, A-10

Model Pain Management Program For Medical School Curricula D-295.982 - Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs.

Res. 308, A-01 Reaffirmed: CME Rep. 2, A-11 Reaffirmed: CME Rep. 6, A-13

Decisions Near the End of Life H-140.966 - Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. (2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment. (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide. (4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time. (5) Our AMA supports continued research into and education concerning pain management.

CEJA Rep. B, A-91 Reaffirmed by BOT Rep. 59, A-96 Reaffirmation A-97 Appended: Sub. Res. 514, I-00 Reaffirmed: CEJA Rep. 6, A-10 Reaffirmed in lieu of Res. 211, I-13

Hospice Care H-85.955 - Our AMA: (1) approves of the physician-directed hospice concept to enable the terminally ill to die in a more homelike environment than the usual hospital; and urges that this position be widely publicized in order to encourage extension and third party coverage of this provision for terminal care; (2) encourages physicians to be knowledgeable of patient eligibility criteria for hospice benefits and, realizing that prognostication is inexact, to make referrals based on their best clinical judgment; (3) supports modification of hospice regulations so that it will be reasonable for organizations to qualify as hospice programs under Medicare; (4) believes that each patient admitted to a hospice program should have his or her designated attending physician who, in order to provide continuity and quality patient care, is allowed and encouraged to continue to guide the care of the patient in the hospice program; (5) supports changes in Medicaid regulation and reimbursement of palliative care and hospice services to broaden eligibility criteria concerning the length of expected survival for pediatric patients and others, to allow provision of concurrent life-prolonging and palliative care, and to provide respite care for family care givers; and (6) seeks amendment of the Medicare law to eliminate the six-month prognosis under the Medicare Hospice benefit and support identification of alternative criteria, meanwhile supporting extension of the prognosis requirement from 6 to 12 months as an interim measure.

CCB/CLRPD Rep. 3, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-16)

Introduced by: M. Zuhdi Jasser, MD, Delegate

Subject: No Compromise on Anti-Female Genital Mutilation Policy

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

- 1 Whereas, Female genital mutilation (FGM) is the forcible mutilation of the clitoris and external
2 genitalia of women and girls for non-medical reasons affecting not only women in Southern
3 Asia, the Middle East and Africa, but also remains within the immigrant communities in the U.S.
4 and Europe; and
5
6 Whereas, FGM practiced on girls typically between 4 and 12 years of age (but can range from
7 birth to prior to marriage) is responsible for the torture, maiming, and mutilation of millions upon
8 millions of women and girls worldwide; and
9
10 Whereas, FGM in any form is a violation of basic human rights and bodily autonomy. It denies
11 the victim physical integrity, a normal sexual life, freedom from violence and subjugation, and
12 most extreme cases, causes death; and
13
14 Whereas, The forcible mutilation of a girl's genitalia in any way sets the stage for male-dominant
15 psychological torture, control, and dehumanization of that girl and woman will suffer in her family
16 forever and can lead to a lifetime of depression, anxiety and trauma; and
17
18 Whereas, Existing AMA Policy H-525.980 explicitly condemns the practice of female genital
19 mutilation (FGM); and
20
21 Whereas, In the U.S. an estimated 513,000 women and girls are at risk of undergoing the
22 procedure back in their home country or the country of their parents and annual International
23 Day of Zero Tolerance to FGM found that 70 million more women and girls have undergone the
24 procedure than previously thought; and
25
26 Whereas, There has recently been significant media coverage in 2016 about recent attempts by
27 some academics and physicians in the American medical community to redefine FGM and
28 promote a type of FGM in the form of a genital 'nick' or 'alteration' as a "compromise" position; and
29
30 Whereas, Our AMA must remain clear in its stance on FGM and reject any type of patriarchal
31 'nicking' procedure as an unethical surrender to the barbaric underpinnings of the FGM culture; and
32
33 Whereas, Any compromise procedure is still FGM and entirely violates existing AMA policy
34 H-525.980 last modified A-12; and
35
36 Whereas, Survivors and advocates against FGM like Khadija Gbla, Leyla Hussein (also a
37 psychotherapist) as well as organizations like No FGM Australia and Amref Health Africa (led by
38 Dr. Githinji Gitahi, a gynecologist) wholly rejected the compromise on FGM; and

1 Whereas, Our AMA, in the spirit of our existing Policy H-525.980, should listen to the victims,
2 advocate on their behalf in the ethical practice of medicine, and update our policy to make it
3 clear in 2016 that our AMA rejects any compromise procedures and that we uncompromisingly
4 stand with individuals and organizations who have experienced FGM and who are surrounded
5 by the horrors of FGM in all its incarnations; and
6

7 Whereas, AMA Policy H-525.980 needs to be updated to reflect not only its condemnation of
8 FGM but its condemnation of any compromise procedures; therefore be it
9

10 RESOLVED, That our American Medical Association reaffirm its policy against female genital
11 mutilation (FGM) (Reaffirm HOD Policy); and be it further
12

13 RESOLVED, That, due to the public debate in 2016 over whether the medical community
14 sanctions a proposed 'nicking procedure,' our AMA must further clarify its current position on
15 FGM to explicitly state that our AMA condemns any and all ritual procedures including, but not
16 limited to, 'nicking' or 'genital alteration' procedures done to the genitals of women and girls
17 (New HOD Policy); and be it further
18

19 RESOLVED, That our AMA, on behalf of the medical community, actively advocate against the
20 practice of FGM in all its forms (including the recently proposed 'nicking' and 'alteration'
21 procedures) and effectively add the voice of America's physicians to the voices of many anti-
22 FGM human rights activists and their organizations which advocate for the survivors and victims
23 of FGM (Directive to Take Action); and be it further
24

25 RESOLVED, That our AMA partner in this public advocacy with reputable anti-FGM activists
26 and survivors including, but not limited to, Jaha Dukureh of the Tahirih Justice Center, Waris
27 Dirie of Desert Flower Foundation, Layla Hussein of the Maya Center and the Dahlia Project,
28 and Nimco Ali of the Daughters of Eve or Safe Hands for Girls to name a few (Directive to Take
29 Action); and be it further
30

31 RESOLVED, That our AMA educate its membership and the American public about the harm of
32 FGM prominently through its website and provide resources about the ethics and medical harm
33 of any and all forms of FGM. (Directive to Take Action)

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

Received: 10/11/16

RELEVANT AMA POLICY

Expansion of AMA Policy on Female Genital Mutilation H-525.980

Our AMA: (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; (4) supports that physicians who are requested to perform genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with societal mores; (5) will work to ensure that medical students, residents, and practicing physicians are made aware of the continued practice and existence of FGM in the United States, its physical effects on patients, and any requirements for reporting FGM; and (6) is in opposition to the practice of female genital mutilation by any physician or licensed practitioner in the United States. CSA Rep. 5, I-94 Res. 513, A-96 Reaffirmed: CSAPH Rep. 3, A-06 Modified: Res. 9, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(I-16)

Introduced by: Washington

Subject: Effective Peer Review

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

- 1 Whereas, The Health Care Quality Improvement Act of 1986 (HCQIA) intended to protect the
2 public from incompetent physicians by allowing those physicians on peer review committees to
3 communicate in an open and honest environment and thus weed out incompetent physicians,
4 without the specter of a retaliatory lawsuit by the reviewed physician; and
5
6 Whereas, Most states have passed statutes that broaden the protections afforded by the HCQIA
7 in order to further promote peer review while severely limiting whistleblower protections to very
8 limited specific situations; and
9
10 Whereas, A number of states have specific whistleblower protections; however, California's
11 Health and Safety Code 1278.5(b)(1)(A) states that no health care facility shall discriminate or
12 retaliate against any person who has "presented a grievance, complaint or report to the facility";
13 and
14
15 Whereas; Common law protections are usually limited to situations where the offensive action
16 violates a clearly articulated public policy; and
17
18 Whereas; Many, if not most, physicians are now either employed or controlled by hospital
19 conglomerates; therefore, the threat of a retaliatory lawsuit is far less threatening than
20 termination of employment or elimination of hospital privileges; and
21
22 Whereas; Our AMA policy does not seem to reflect the dramatic recent change in workplace
23 arrangements nor protect employed physicians from retaliation as a result of effective peer
24 review; therefore be it
25
26 RESOLVED, That our American Medical Association study the current environment for effective
27 peer review, on both a federal and state basis, in order to update its current policy to include
28 strategies for promoting effective peer review by employed physicians as well as consider a
29 national strategy for protecting all physicians from retaliation as a result from participating in
30 effective peer review. (Directive to Take Action)

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

Received: 10/13/16

RELEVANT AMA POLICY

Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations H-375.965

AMA policy is that:

(1) Summary suspension of clinical privileges is an extraordinary remedy which should be used only when the physician's continued practice presents an "imminent danger to the health of any individual." The decision to summarily suspend a member's medical staff membership or clinical privileges should be made by the chief of staff, chair or vice-chair of the member's clinical department, or medical executive committee. The medical executive committee (MEC) must meet as soon as possible, but in no event more than 14 days after the summary suspension is imposed, or before the time in which a report would be required to the state licensing agency if applicable, whichever is shorter, to review and consider the summary suspension. The MEC shall then promptly modify, continue or terminate the summary suspension. The suspended physician must be invited to attend and make a statement concerning the issues under investigation, but the meeting with the MEC shall not constitute the physician's fair hearing. If the MEC sustains the suspension, said action will trigger the fair hearing procedures contained in these policies.

(2) At the request of a medical staff department or of a member under review, or at its own initiative if needed for adequate and unbiased review, the medical executive committee may arrange, through the state or local medical society, the relevant specialty society or other appropriate source, for an external hearing panel to hear the case in order to assure professional and impartial clinical assessment.

(3) Prior to any disciplinary hearing, the physician should be provided with a clear, and if applicable, clinically supported basis for the proposed professional review action. A hearing panel of a health care organization should be guided by generally accepted clinical guidelines and established standards in its review actions.

(4) Physician health and impairment issues should be identified and managed by a medical staff committee, which should operate separately from the disciplinary process.

(5) Summary suspension reports that do not adhere to these principles should not be circulated or posted without confirmation by a state medical board or other appropriate authority allowing due process.

(6) Summary suspension reports should be immediately retracted or removed from posting if reversed or where a physician is exonerated.

(7) Physicians who are the subject of a summary suspension report should be afforded the right to add a statement or notice of dispute to the report that is of reasonable length.

BOT Action in response to referred for decision BOT Rep. 23, A-05; BOT Action in response to referred for decision Res. 220, I-08

<http://www.ama-assn.org/meetings/public/annual05/bot23a05.doc>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(I-16)

Introduced by: Washington

Subject: Fair Process for Employed Physicians

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(John P. Abenstein, MD, Chair)

- 1 Whereas, Employed physicians face unique challenges in that they are held accountable but
2 sometimes not given enough resources or authority; and
3
4 Whereas, Employed physicians sometimes face moral dilemmas within the workplace regarding
5 processes beyond their control, creating increased stress and even depression; often
6 contributing to physician burnout; and
7
8 Whereas, Fear of retaliation and the stigma associated with being a “troublemaker” or not being
9 a team player contributes to underreporting of problems in health care; and
10
11 Whereas, The more responsibility the physician has, the greater the exposure to serious events;
12 and
13
14 Whereas, Physicians find themselves facing a dilemma if their employer will not correct the
15 problem/situation; therefore be it
16
17 RESOLVED, That our American Medical Association support whistleblower protections for
18 health care providers and parties who raise questions of quality, safety, and efficacy of health
19 care and are adversely treated by any health care organization or entity (New HOD Policy); and
20 be it further
21
22 RESOLVED, That our AMA advocate for protection in medical staff bylaws to minimize negative
23 repercussions for physicians who report problems within their workplace. (New HOD Policy)

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

Received: 10/13/16