

**American Medical Association, September 2005
GLBT POLICY COMPENDIUM**

H-295.878 Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care-without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to include Lesbian, Gay, Bisexual, and Transgender health issues in the cultural competency curriculum for medical education. (Res. 323, A-05)

D-65.995 Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families

Our AMA will work to reduce the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children. (Res. 445, A-05)

H-60.940 Partner Co-Adoption

Our AMA will support legislative and other efforts to allow the adoption of a child by the same-sex partner, or opposite sex non-married partner, who functions as a second parent or co-parent to that child. (Res. 204, A-04)

H-65.976 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or perceived gender" in any nondiscrimination statement. (Res. 414, A-04)

H-65.979 Sexual Orientation as an Exclusionary Criterion for Youth Organization.

Our AMA asks youth oriented organizations to reconsider exclusionary policies that are based on sexual orientation. (Res. 414, A-01)

H-65.983 Nondiscrimination Policy.

The AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation. (Res. 1, A-93; Reaffirmed: CCB Rep. 6, A-03)

H-65.990 Civil Rights Restoration.

The AMA 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. (BOT Rep. LL, I-86; Amended by Sunset Report, I-96; Modified: Res. 410, A-03)

H-65.992 Continued Support of Human Rights and Freedom.

Our AMA continues (1) to support the dignity of the individual, human rights and the sanctity of human life, and (2) to oppose any discrimination based on an individual's sex, sexual orientation, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies. (Sub. Res. 107, A-85; Modified by CLRPD Rep. 2, I-95; Reaffirmation A-00)

H-160.991 Health Care Needs of the Homosexual Population.

Our AMA: (1) believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness. In the

case of the homosexual patient this is especially true, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between physician and the homosexual patient effective progress can be made in treating the medical needs of this particular segment of the population; (2) is committed to taking a leadership role in: (a) educating physicians on the current state of research in and knowledge of homosexuality and the need to take an adequate sexual history; these efforts should start in medical school, but must also be a part of continuing medical education; (b) educating physicians to recognize the physical and psychological needs of their homosexual patients; (c) encouraging the development of educational programs for homosexuals to acquaint them with the diseases for which they are at risk; (d) encouraging physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the medical needs of this population; and (e) working with the gay and lesbian community to offer physicians the opportunity to better understand the medical needs of homosexual and bisexual patients; and (3) opposes, the use of "reparative" or "conversion" therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00)

H-180.980 Sexual Orientation as Health Insurance Criteria.

The AMA opposes the denial of basis of sexual orientation. (Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97) health insurance on the basis of sexual orientation.

H-225.961 Medical Staff Development Plans

1. All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria.

Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals.

2. The AMA communicates the medical staff development plan principles to the President and Chair of the Board of the American Hospital Association and recommend that state and local

medical associations establish a dialogue regarding medical staff development plans with their state hospital association. BOT Rep. 14, A-98)

H-270.997 Legal Restrictions on Sexual Behavior Between Consenting Adults

Our AMA supports in principle repeal of laws which classify as criminal any form of noncommercial sexual conduct between consenting adults in private, saving only those portions of the law which protect minors, public decorum, or the mentally incompetent. (BOT Rep. I, A-75; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-295.955 Teacher-Learner Relationship In Medical Education.

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

CODE OF BEHAVIOR The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct. A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

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

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication. On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians. While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively. Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients. (BOT Rep. ZZ, I-90; Reaffirmed by CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, I-99)

H-295.969 Nondiscrimination Toward Medical School and Residency Applicants on the Basis of Sexual Orientation.

Our AMA urges (1) the Liaison Committee on Medical Education to amend the Standards for Accreditation of Medical Education Programs Leading to the MD Degree, Part 2, Medical Students, Admissions to read: "In addition, there must be no discrimination on the basis of sex, age, race, creed, national origin or sexual orientation"; and (2) the Accreditation Council for Graduate Medical Education to amend the "General Essentials of Accredited Residencies, Eligibility and Selection of Residents" to read: "There must be no discrimination on the basis of sex, age, race, creed, national origin or sexual orientation." (Res. 12, A-89; Reaffirmed: Sunset Report, A-00)

H-440.885 National Health Survey

Our AMA supports a national health survey that incorporates a representative sample of the U.S. population of all ages (including adolescents) and includes questions on sexual orientation and sexual behavior. (CSA Rep. 4, A-03)

E-9.03 Civil Rights and Professional Responsibility.

Opportunities in medical society activities or membership, medical education and training, employment, and all other aspects of professional endeavors should not be denied to any duly licensed physician because of race, color, religion, creed, ethnic affiliation, national origin, sex, sexual orientation, age, or handicap. (IV) Issued prior to April 1977; Updated June 1994.

E-9.12 Patient-Physician Relationship: Respect for Law and Human Rights.

The creation of the patient-physician relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, or any other basis that would constitute invidious discrimination. Furthermore, physicians who are obligated under pre-existing contractual arrangements may not decline to accept patients as provided by those arrangements. (I, III, V, VI) Issued July 1986; Updated June 1994.

E-10.05 Potential Patients.

(1) Physicians must keep their professional obligations to provide care to patients in accord with their prerogative to choose whether to enter into a patient-physician relationship. (2) The following instances identify the limits on physicians' prerogative: (a) Physicians should respond to the best of their ability in cases of medical emergency (Opinion 8.11, "Neglect of Patient"). (b) Physicians cannot refuse to care for patients based on race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination (Opinion 9.12, "Patient-Physician Relationship: Respect for Law and Human Rights"), nor can they discriminate against patients with infectious diseases (Opinion 2.23, "HIV Testing"). (c) Physicians may not refuse to care for patients when operating under a contractual arrangement that requires them to treat (Opinion 10.015, "The Patient-Physician Relationship"). Exceptions to this requirement may exist when patient care is ultimately compromised by the contractual arrangement. (3) In situations not covered above, it may be ethically permissible for physicians to decline a potential patient when: (a) The treatment request is beyond the physician's current competence. (b) The treatment request is known to be scientifically invalid, has no medical indication, and offers no possible benefit to the patient (Opinion 8.20, "Invalid Medical Treatment"). (c) A specific treatment sought by an individual is incompatible with the physician's personal, religious, or moral beliefs. (4) Physicians, as

professionals and members of society, should work to assure access to adequate health care (Opinion 10.01, "Fundamental Elements of the Patient-Physician Relationship").* Accordingly, physicians have an obligation to share in providing charity care (Opinion 9.065, "Caring for the Poor") but not to the degree that would seriously compromise the care provided to existing patients. When deciding whether to take on a new patient, physicians should consider the individual's need for medical service along with the needs of their current patients. Greater medical necessity of a service engenders a stronger obligation to treat. (I, VI, VIII, IX) Issued December 2000 based on the report "Potential Patients, Ethical Considerations," adopted June 2000. Updated December 2003. * Considerations in determining an adequate level of health care are outlined in Opinion 2.095, "The Provision of Adequate Health Care."

B-6.4024 Council on Ethical and Judicial Affairs.

To receive appeals filed by applicants who allege that they, because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation or age, or for any other reason unrelated to character or competence have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure, or in the event of repeated violations, recommend to the House of Delegates that the constituent and/or component association involved be declared to be no longer a constituent and/or component member of the AMA;

B-1.50 Discrimination

Membership in any category of the American Medical Association or in any of its constituent associations shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, age, or for any other reason unrelated to character or competence. Nor shall membership in any category of the AMA or in any of its constituent associations be denied to any person who meets the requirements for membership as set forth in these Bylaws and in the bylaws of the applicant's respective constituent association. In considering applicants for membership, information as to the character, ethics, professional status, and professional activities of the individual may be considered.

G-630.130 Discrimination

It is the policy of our AMA not to hold meetings or pay member, officer or employee dues in any club, restaurant, or other institution that has exclusionary policies based on gender, race, color, religion, national origin, or sexual orientation. (Res. 101, I-90; Reaffirmed: Sunset Report, I-00; Consolidated: CLRPD Rep. 3, I-01)

D-65.996 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population

Our AMA will encourage and work with state medical societies to provide a sample printed nondiscrimination policy suitable for framing, and encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or perceived gender." (Res. 414, A-04)

D-295.995 Adoption of Sexual Orientation Nondiscrimination and Gender Identity in LCME Accreditation

Our AMA will urge the Liaison Committee on Medical Education to expand its current accreditation standard to include a nondiscriminatory statement related to all aspects of medical education, and to specify that the statement must address sexual orientation. (Res. 305, A-99)

D-515.997 School Violence

Our AMA will collaborate with the US Surgeon General on the development of a comprehensive report on youth violence prevention, which should include such issues as bullying, racial prejudice, discrimination based on sexual orientation, and similar behaviors and attitudes. (CSA Rep. 11, I-99)