American Medical Association

National Advisory Council on Violence and Abuse

Policy Compendium

April 2008

Foreword

This booklet contains policy excerpts from the AMA's PolicyFinder that are of special interest to the American Medical Association's National Advisory Council on Violence and Abuse (NACVA) and does not represent the complete list of AMA policies. For a complete listing of all AMA policies, consult the AMA's PolicyFinder at: http://www.ama-assn.org/ama/noindex/category/11760.html.

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Child Abuse & Neglect

H-60.948 Child Protection Legislation

The AMA opposes legislation that would: (1) hinder, obstruct or weaken investigations of suspected child and adolescent abuse, and (2) hamper or interfere with child protection statutes. (Sub. Res. 219, I-97; Reaffirmed: BOT Rep. 33, A-07)

D-60.982 Long Term Effects of Early Abuse/Neglect on Brain Development

Our AMA will:

(1) work with national organizations, e.g., American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American College of Obstetricians and Gynecologists, and others involved with early brain research, child abuse and neglect and public education to make educational materials available to hospital infant and pediatric personnel, physicians, parents, other child care providers and educators and the public at large;

(2) urge state and local medical societies to work with their legislators to put in place educational, and where appropriate, support programs for those involved with infants and young children, i.e., parents, students in junior and senior high school, child care providers, and early childhood educators; and

(3) work with the federal government and pertinent agencies to make this issue--prevention of early abuse and brain damage with its devastating long term effects for individuals and society--a priority of our nation. (BOT Action in response to referred for decision Res. 526, A-02)

H-60.961 HHS to Require the States to Repeal the Religious Exemption in the Child Abuse and Neglect Prevention Statutes

The AMA will petition the Secretary of HHS to remove the religious exemption in child abuse and neglect cases from the Code of Federal Regulations and to exercise administrative authority to urge state officials to repeal existing child abuse and neglect religious exemption provisions in state statutes, thereby restoring equal protection under the law for all children. (Sub. Res. 219, A-93; Reaffirmed by BOT Rep. 24, A-97)

H-60.992 Missing and Exploited Children

To enhance physician involvement with issues related to missing and exploited children, the AMA supports the following statements and activities: (1) Child abductions and runaway behaviors are harmful and emotionally upsetting, divisive, and chaos-producing to victims and their families. Any disappearance of a child constitutes a family crisis with both victims and families at high risk for developing physical and emotional problems. Any child who is the object of a custody dispute is vulnerable to parental

snatching, running away and/or being abused. (2) Medical interventions, including family therapy, should occur immediately after a child is reported missing; if the child returns home or is found dead, physicians and other health care professionals should continue to monitor the victim patient and/or the patient's family. (3) Children abducted by family members or strangers should be considered victims of child abuse and such occurrences should be designated as reportable instances of child abuse under state statutes. (4) Prevention efforts should focus on reducing family stress, combating alcoholism and drug abuse, dealing with poor marital relationships including divorce mediation and counseling, and providing supportive services for families at risk. (5) All shelter services that are presently available to runaways and homeless youths should contain a high quality health care component. Comprehensive standards of health care should be developed for the national network of runaway centers. Physicians should be consultants to and work with governing boards of these agencies. (6) Children's medical records should be intelligible and include a complete medical history, distinguishing physical characteristics and detailed information, as outlined in the Child Identification Form developed by the AMA. The AMA encourages physicians to utilize this form in their practice settings. Pediatricians and family physicians should encourage parents to arrange for the speedy transfer of the child's previous medical records and physicians should respond promptly to such requests. The parent's refusal to comply with this request should warrant further questioning of the parents or a report of a possible missing child. (7) At prevention, diagnostic and treatment levels, physicians should attempt to identify troubled children and their families early and ensure that appropriate treatment takes place or that referrals are made to the other medical specialists or community resources. (8) The primary care physician, medical examiner and dentist are key members of the missing child identification team, and should be knowledgeable about the steps to be taken (completing the NCIC forms) immediately after a child is reported missing. (9) Physicians should actively promote the practice of obtaining clear and readable fingerprints and footprints as a technically useful way to document these unique physical characteristics of children. (10) State medical societies should consider establishing committees on child abuse and neglect, with the topic of missing and exploited children included in the charge of responsibilities. (11) The AMA supports continued research on abducted children (both parent and stranger abductions), runaways, homeless youth and their families, and how physicians can help them. (12) All levels of medical education should emphasize the diagnosis, comprehensive treatment and prevention of problems associated with families that suffer from stress and that may be related to problems of alcoholism, drug abuse, domestic violence and marital dysfunction. Educational programs should address the reactions of physicians to these complex and frustrating social problems. (13) The AMA supports cooperating with the American Academy of Pediatrics, the American Psychiatric Association, the American College of Obstetricians and Gynecologists, and the College of American Pathologists in developing and disseminating information about the health care needs of missing children and effective prevention strategies. (14) The AMA supports cooperating with the American Bar Association, the American Psychiatric Association, law enforcement agencies and the National Center for Missing and Exploited Children in considering the problem of identifying and tracking perpetrators of child abductions.

(BOT Rep. O, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

H-75.991 Requirements or Incentives by Government for the Use of Long-Acting Contraceptives

(1) Involuntary use of long-acting contraceptives because of child abuse raises serious questions about a person's fundamental right to refuse medical treatment, to be free of cruel and unusual punishment, and to procreate. The state's compelling interest in protecting children from abuse may be served by less intrusive means than imposing contraception on parents who have committed child abuse. The needs of children may be better met by providing close supervision of the parents, appropriate treatment and social services, and foster placement care when necessary. There is not sufficient evidence to demonstrate that long-acting contraceptives are an effective social response to the problem of child abuse. Before long-acting contraceptives could be considered as a response to individual cases of child abuse, the issue would need to be addressed by society broadly. Society must be careful about taking shortcuts to save resources when constitutional rights are involved.

(2) Serious questions are raised by plea bargains, or negotiations with child welfare authorities, that result in the use of long-acting contraceptives. Such agreements are made in inherently coercive environments that lack procedural safeguards. In addition, cultural and other biases may influence decisions by the state to seek the use of a long-acting contraceptive.

(3) If welfare or other government benefits were based on the use of long-acting contraceptive agents, individuals would be required to assume a potentially serious health risk before receiving their benefits. Government benefits should not be made contingent on the acceptance of a health risk.

(4) Individuals should not be denied access to effective contraception because of their indigence. Use of long-acting contraceptives should be covered by Medicaid and other health insurance programs, both public and private.

(5) Long-acting contraceptives may be medically contraindicated. Assessing the health risks of long-acting contraceptives is substantially outside the purview of courts and legislatures. (BOT Rep. EE, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04)

H-245.984 Treatment Decisions for Seriously Ill Newborns

Physicians should play an active role in advocating for changes in the Child Abuse Prevention Act as well as state laws that require physicians to violate the ethical guidelines stated in E-2.215 (Treatment Decisions for Seriously Ill Newborns). (CEJA Rep. I, A-92; Modified and Reaffirmed: CEJA Rep. 1, A-03)

H-515.973 Memories of Childhood Abuse

The AMA: (1) recognizes that few cases in which adults make accusations of childhood sexual abuse based on recovered memories can be proved or disproved and it is not yet known how to distinguish true memories from imagined events in these cases; (2) encourages physicians to address the therapeutic needs of patients who report memories of childhood sexual abuse and that these needs exist quite apart from the truth or falsity of any claims; and (3) encourages physicians treating possible adult victims of childhood abuse to subscribe to the *Principles of Medical Ethics* when treating their patients and that psychiatrists pay particular attention to the *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*. (CSA Rep. 5, A-94; Reaffirmed: CSA Rep. 8, A-05)

H-515.988 Repeal of Religious Exemptions in Child Abuse and Medical Practice Statutes

Our AMA (1) reaffirms existing policy supporting repeal of the religious exemption from state child abuse statutes; (2) recognizes that constitutional barriers may exist with regard to elimination of the religious exemption from state medical practice acts; and (3) encourages state medical associations that are aware of problems with respect to spiritual healing practitioners in their areas to investigate such situations and pursue all solutions, including legislation where appropriate, to address such matters. (BOT Rep. H, A-90; Reaffirmed: Sunset Report, I-00)

Child Sexual Abuse

H-60.990 Child Pornography

The AMA (1) supports reassembling an interdisciplinary panel of experts periodically to continue to address shared concerns and information relevant to the issue of child pornography; (2) encourages and promotes awareness of child pornography issues among physicians; (3) through physicians, encourages parents to use the educational textbook entitled, Sex Talk for a Safe Child; (4) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (5) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; (6) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities; and (7) cooperates with other national organizations and federal and local agencies in addressing the problem of child pornography. (BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98)

H-515.989 Evidence of Standards for Child Sexual Abuse

The AMA continues to support the standardization of evidence in child sexual abuse cases and urges that examination and treatment of child abuse victims be done by a

physician. (Res. 78, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-525.980 Expansion of AMA Policy on Female Genital Mutilation

The 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; and (4) supports that physicians who are requested to perform female 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 changing societal mores. (CSA Rep. 5, I-94; Res. 513, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

School & Youth Violence

H-60.943 Bullying Behaviors Among Children and Adolescents

Our AMA: (1) recognizes bullying as a complex and abusive behavior with potentially serious social and mental health consequences for children and adolescents. Bullying is defined as a pattern of repeated aggression; with deliberate intent to harm or disturb a victim despite apparent victim distress; and a real or perceived imbalance of power (e.g., due to age, strength, size), with the more powerful child or group attacking a physically or psychologically vulnerable victim;

(2) advocates for federal support of research: (a) for the development and effectiveness testing of programs to prevent or reduce bullying behaviors, which should include rigorous program evaluation to determine long-term outcomes; (b) for the development of effective clinical tools and protocols for the identification, treatment, and referral of children and adolescents at risk for and traumatized by bullying; (c) to further elucidate biological, familial, and environmental underpinnings of aggressive and violent behaviors and the effects of such behaviors; and (d) to study the development of social and emotional competency and resiliency, and other factors that mitigate against violence and aggression in children and adolescents;

(3) urges physicians to (a) be vigilant for signs and symptoms of bullying and other psychosocial trauma and distress in children and adolescents; (b) enhance their awareness of the social and mental health consequences of bullying and other aggressive behaviors; (c) screen for psychiatric comorbidities in at-risk patients; (d) counsel affected patients and their families on effective intervention programs and coping strategies; and (e) advocate for family, school, and community programs and services for victims and perpetrators of bullying and other forms of violence and aggression;

(4) advocates for federal, state, and local resources to increase the capacity of schools to provide safe and effective educational programs by which students can learn to reduce and prevent violence. This includes: (a) programs to teach, as early as possible, respect and tolerance, sensitivity to diversity, and interpersonal problem-solving; (b) violence reduction curricula as part of education and training for teachers, administrators, school staff, and students; (c) age and developmentally appropriate educational materials about the effects of violence and aggression; (d) proactive steps and policies to eliminate bullying and other aggressive behaviors; and (e) parental involvement;

(5) advocates for expanded funding of comprehensive school-based programs to provide assessment, consultation, and intervention services for bullies and victimized students, as well as provide assistance to school staff, parents, and others with the development of programs and strategies to reduce bullying and other aggressive behaviors; and

(6) urges parents and other caretakers of children and adolescents to: (a) be actively involved in their child's school and community activities; (b) teach children how to interact socially, resolve conflicts, deal with frustration, and cope with anger and stress; and (c) build supportive home environments that demonstrate respect, tolerance, and caring and that do not tolerate bullying, harassment, intimidation, social isolation, and exclusion. (CSA Rep. 1, A-02)

H-145.983 School Violence

The AMA encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property. (Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05)

D-515.986 Update on Youth and School Violence

Our AMA will re-examine its role in implementing current AMA policies related to violence prevention, and include such issues in a strategic issue paper. (CSAPH Rep. 2, I-07)

D-515.987 Prevention of Violence in Schools

Our AMA will continue to study the timely issue of violence in our schools, including youth violence prevention and early identification and intervention, and issue a report at the 2007 Annual Meeting of the House of Delegates. (Res. 608, I-06)

D-515.989 AMA Leadership in Dealing with Recent Mass Assaults

Our AMA will continue to study the timely issue of violence in our schools, including youth violence prevention and early identification and intervention, and issue a report at the 2007 Annual Meeting of the House of Delegates. (Res. 608, I-06).

D-515.995 Time for Action on Youth Violence

Our AMA will advocate for a national task force of diverse organizations to address youth violence prevention (and not solely limited to school violence and community violence). (Res. 419, I-01)

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 or gender identity, and similar behaviors and attitudes. (CSA Rep. 11, I-99; Modified: BOT Rep. 11, A-07)

D-515.999 Research on Violence in School Settings

Our AMA will work with all appropriate specialty societies to review the: (1) existing scientific literature concerning the incidence and causes of violence in school settings; (2) existing scientific evidence concerning the effect of media reporting of violent events on the behavior of others (e.g., the "contagion" or "copycat" effect); and (3) research data on the efficacy of school-based violence prevention programs. (Res. 403, I-98)

Violence in the Media

H-60.983 Statement of Concern Regarding Destructive Themes Contained in Rock Music

(1) The AMA is concerned about the possible impact of destructive themes depicted in certain types of popular rock music. The vivid depiction of drug and alcohol use, suicide, violence, demonology, sexual exploitation, racism and bigotry could be harmful to some young people, especially vulnerable children and adolescents who are socially alienated from traditional value systems and positive support groups. (2) The AMA urges four activities: (a) parents should be aware of the themes depicted in music; monitor the concerts their children attend, the music videos they watch, and the albums they purchase and discuss the potential harmful effects of music themes with their children; (b) physicians should know about potentially destructive themes in some forms of rock music, and should work to increase awareness of patients and communities about these themes; (c) members of the entertainment industry, including sponsors of concerts, agents, and entertainers, should exercise greater responsibility in presenting music to young people; and (d) all music industry companies should voluntarily label albums in compliance with recently agreed upon labeling standards. (CSA Rep. E, A-90; Reaffirmed in lieu of Res. 414, I-94; Reaffirmed by Res. 420, A-95; Reaffirmed: CSA Rep. 8, A-05)

H-485.995 TV Violence

The AMA reaffirms its vigorous opposition to television violence and its support for efforts designed to increase the awareness of physicians and patients that television violence is a risk factor threatening the health of young people. (Res. 19, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-515.974 Mass Media Violence and Film Ratings

Redressing Shortcomings in the Current System: The AMA: (1) will speak out against the excessive portrayal of violence in the news and entertainment media, including newscasts, movies, videos, computer games, music and print outlets, and encourage the depiction of the medical, social and legal consequences of violence by the media;

(2) urges the entertainment industry to make fundamental changes in the rating system, which will give consumers more precise information about violent and sexual content of motion pictures, television and cable television programs, and other forms of video and audio entertainment, thereby enabling consumers to make more meaningful decisions for themselves and their children about what they view or hear;

(3) works with the entertainment industry and other groups interested in reducing violent content of media programming, to incorporate age classifications into the ratings system that reflect scientifically demonstrated developmental periods during childhood and adolescence such as ages 3- to 7-year-olds, 8- to 12-year-olds, and 13- to 17-year-olds. The AMA will expand its national campaign against violence to include media violence; and promotes campaigns similar to the Minnesota Medical Association's campaign throughout the entire federation;

(4) urges the entertainment industry to develop a uniform ratings system that is easy for consumers to understand and which can be applied across existing and future entertainment technologies;

(5) uses physicians to counsel parents about the known effects of media violence on children's behavior and encouraging them to reduce the amount of violent programming viewed by their children;

(6) monitors changes in the current ratings system and working through state medical societies to inform physicians and their patients about these changes;

(7) urges consideration be given to the potential development of a Television Violence Code with input from the government, the television industry, and the public, including the medical profession, to address issues relating to all television violence, including news reports and entertainment; and

(8) supports all other appropriate measures to address and reduce television, cable television, and motion picture violence. (BOT Rep. 18, A-94; Modified: Res. 417, I-95; Appended: Sub. Res. 419, A-98)

D-515.991 Labeling of Video Game Content

Our AMA will actively campaign for appropriate labeling of any video game that depicts acts of violence or aggressive acts so that these videos will be made available for purchase by adults only. (Res. 421, A-05)

Adolescent Interpersonal Violence

H-60.938 Adolescent Sexual Activity

1. Our AMA (a) endorses the joint position "Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse"; and (b) supports the following principles for consideration in development of public policy: (i) Sexual activity and sexual abuse are not synonymous and that many adolescents have consensual sexual relationships; (ii) It is critical that adolescents who are sexually active receive appropriate confidential health care and screening; (iii) Open and confidential communication between the health professional and adolescent patient, together with careful clinical assessment, can identify the majority of sexual abuse cases; (iv) Physicians and other health care professionals must know their state laws and report cases of sexual abuse to the proper authority in accordance with those laws, after discussion with the adolescent and/or parent as appropriate; (v) Federal and state laws should support physicians and other health care professionals in their role in providing confidential health care to their adolescent patients; and (vi) Federal and state laws should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity.

2. Our AMA will (a) develop and disseminate to national medical specialty societies and state medical associations information that includes guidance on removing barriers faced by sexually active adolescents who seek confidential health care; and (b) develop model legislation which supports AMA policy regarding adolescent sexual activity and confidentiality. (Res. 825, I-04)

D-60.994 Sexually Transmitted Diseases Among Adolescents, Including Incarcerated Juveniles

Our AMA will increase its efforts to work in conjunction with the National Commission on Correctional Health Care to ensure that juveniles in correctional facilities receive comprehensive screening and treatment for sexually transmitted diseases and sexual abuse. (Res. 401, A-01)

H-515.981 Family Violence-Adolescents as Victims and Perpetrators

The AMA (1) will use its communications mechanisms to (a) encourage physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urge physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence. (CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03)

D-515.998 Resources for Victims of Domestic Abuse in the Adolescent Population

Our AMA will develop materials on domestic violence, partner abuse, date violence, and sexual violence (including but not limited to sexual assault, sexual harassment, stalking, and cyber stalking) that are suitable for use in junior high and high schools and work with the Alliance and state medical societies in an effort to ensure the distribution and placement of these materials in junior high and high schools around the country. (Sub. Res. 410, I-98; Modified: Res. 406, A-07)

Community Violence

H-10.982 Injury Prevention

Our AMA (1) supports the CDC's efforts to (a) conduct research, (b) develop a national program of surveillance and focused interventions to prevent injuries, and (c) evaluate the effectiveness of interventions, implementation strategies, and injury prevention programs;

(2) supports a Public Health Service public information campaign to inform the public and its policymakers of the injury problem and the potential for effective intervention;

(3) supports the development of a National Center for Injury Control at the CDC; and

(4) encourages state and local medical societies to support, in conjunction with state and local health departments, efforts to make injury control a priority, and advise the leadership of the United States Congress of this unqualified support; and the AMA remains open to working with all interested parties in efforts to deal with and lessen the effects of violence in our society. (Res. 410, A-92; Reaffirmed by BOT Rep. 19 - I-94; Reaffirmed by BOT Rep. 34, A-95; Modified and Reaffirmed by BOT Rep. 52, I-95; Reaffirmed: CSA Rep. 8, A-05)

H-515.971 Public Health Policy Approach for Preventing Violence in America

The AMA supports the ongoing efforts of the CDC to develop appropriate and useful surveillance methodologies for tracking violence-related injuries and encourages the CDC to develop tracking strategies that can be efficiently implemented by physicians, with careful evaluations of pilot programs and demonstration projects prior to their implementation, and will report back on these CDC efforts. (BOT Rep. 34, A-95; Reaffirmed by BOT Rep. 16, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-515.979 Violence as a Public Health Issue

The AMA reaffirms and expands current policy by (a) declaring violence in America to be a major public health crisis; and (b) supporting research into the causes of violent behavior and appropriate interventions which may result in its prevention or cure. (Sub. Res. 408, I-92; Amended: CSA Rep. 8, A-03)

Suicide

H-25.992 Senior Suicide

It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors. (Res. 107, I-90; Reaffirmed: Sunset Report, I-00)

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

Our AMA recognizes teen and young-adult suicide as a serious health concern in the US. (Res. 424, A-05)

D-60.978 Resources to Combat Teen and Young Adult Suicide in the United States

Our AMA will convene a time-limited work group to meet through conference call to identify and evaluate appropriate resources for physicians intended to prevent and

reduce teen and young adult suicide, and that such resources be maintained on a publicly accessible Web page hosted by our AMA. (CSAPH Rep. 3, I-06)

H-60.980 Child and Adolescent Suicide

It is the policy of the AMA to express its opposition to media presentations which directly or indirectly encourage suicide in young children and adolescents. (Res. 115, I-90; Modified: Sunset Report, I-00)

D-60.983 Teen and Young Adult Suicide in the United States

Our AMA will work with appropriate federal agencies, national organizations, and medical specialty societies to compile resources to reduce teen and young-adult suicide, including but not limited to continuing medical education classes, patient education programs, and other appropriate educational and interventional programs for health care providers, and report back at the 2006 Interim Meeting. (Res. 424, A-05)

H-140.949 Physician-Assisted Suicide

The AMA will (1) initiate an educational campaign to make palliative treatment and care directions based on values-based advance care planning the standard of care for meeting the needs of patients at the end of life; and (2) will work with local, state, and specialty medical societies to develop programs to: facilitate referrals to physicians qualified to provide necessary palliative and other care for patients seeking help in meeting their physiological and psychological needs at the end of life; and establish a faculty of physicians with expertise in end-of-life care who can provide consultations for other physicians in caring for patients at the end of life. (BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99)

H-140.952 Physician Assisted Suicide

It is the policy of the AMA that: (1) Physician assisted suicide is fundamentally inconsistent with the physician's professional role. (2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide. (3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease. (4) Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family

counseling and other modalities, should be sought as clinically indicated. (5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. (CEJA Rep. 8, I-93; Reaffirmed by BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99)

H-140.966 Decisions Near the End of Life

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)

H-270.965 Physician-Assisted Suicide

Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician’s role as healer. (Sub. Res, 5, I-98)

D-345.993 Physician Suicide

Our AMA will: (1) work with the American Foundation for Suicide Prevention and the Federation of State Physician Health Programs to study, to educate physicians, and to increase awareness through medical schools, state physician health committees, the AMA Alliance, and internal publications to anticipate, mitigate and eliminate, as far as possible, the preventable endemic catastrophe of physician suicide; and (2) contact the director of the Substance Abuse and Mental Health Services Administration and the American Psychiatric Association to join with the initiative to explore ways to act now to reduce the high prevalence of suicide in the United States particularly among physicians. (Res. 429, A-06)

D-345.995 Responding to Depression, Suicide, Substance Use, and Addiction on College Campuses

Our AMA:

(1) Council on Medical Service will evaluate health insurance coverage of full-time undergraduate and graduate students. (2) Will recommend that any such insurance coverage should have full parity for mental health and substance abuse treatment, which is consistent with established AMA policy (H-185.974, AMA Policy Database). (3) Will recommend that colleges and universities increase the availability and ensure the quality and quantity of on-site mental health and substance abuse clinical services and/or improve access to appropriate community services. (4) Will advocate for the elimination of college and university policies that discriminate against students who disclose or seek treatment for depression, substance use disorders, or other mental health issues, including polices that mandate suspension or withdrawal from school for students who request or receive psychiatric or addiction medicine services. (5) Will encourage the Association of American Medical Colleges (AAMC) to develop similar programs in medical schools. (6) Will encourage clinical staff of campus health services and campus counseling services of colleges and universities to improve their skills in screening, brief intervention and referral for students' problem drinking. (7) Will seek funding in cooperation with interested partners to educate physicians and the media to focus attention on the issues and linkages of substance use and addiction, mental disorders, and suicide among college students. (CSAPH Rep. 8, A-06)

D-345.996 Depression and Suicide on College Campuses

Our AMA will: (1) work in conjunction with all appropriate specialty societies to prepare a report on depression, substance abuse, and suicide on college campuses and will include in its report a review of available scientific data on the efficacy of prevention programs aimed at reducing the incidence of depression, substance abuse, and suicide on college campuses; (2) review the existing data on access to and utilization of college mental health and substance abuse services; and (3) advocate for the development of guidelines concerning appropriate access to psychiatric, addiction medicine, and other mental health and substance abuse services on college campuses. (Res. 425, A-05)

E-2.211 Physician-Assisted Suicide

Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV) Issued June 1994 based on the reports "Decisions Near the End of Life," adopted June 1991, and "Physician-Assisted Suicide," adopted December 1993 (JAMA. 1992; 267: 2229-33); Updated June 1996.

Family Violence

H-515.963 Diagnosis and Management of Family Violence

Our AMA recommends that questions to assess risk for family violence should be included within the context of taking a routine social history, past medical history, history of present illness, and review of systems as part of emergency, diagnostic, preventive, and chronic care management. (CSA Rep. 7, A-05)

H-515.965 Family and Intimate Partner Violence

(1) Our AMA believes that all forms of family and intimate partner violence are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of victims. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society. Our AMA's efforts will be guided, in part, by its Advisory Council on Family Violence.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and

specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula when developed. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist victims. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter victims on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for victims of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from victimization; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either victims or abusers themselves; (h) Give due validation to the experience of victimization and of observed symptomatology as possible sequelae; (i) Record a patient’s victimization history, observed traumata potentially linked to the victimization, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level;

(4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters. (b) Believes it is critically important that programs be available for victims and perpetrators of intimate violence. (c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult victims of intimate partner violence if the required reports identify victims. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of victims' identities; (b) allow competent adult victims to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that: (a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use. (b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence. (c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems. (d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior. (e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. (CSA Rep. 7, I-00)

H-515.975 Alcohol, Drugs, and Family Violence

(1) Given the association between alcohol and family violence, physicians should be alert to look for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse, should screen for alcohol use. (2) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence. (3) Physicians should be alert to the association, especially

among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems. (4) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior. (5) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. (CSA Rep. A, A-93; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: CSA Rep. 8, A-03)

H-515.983 Physicians and Family Violence

Ethical Considerations:

(1) The medical profession must demonstrate a greater commitment to ending family violence and helping its victims. Physicians must play an active role in advocating increased services for victims and abusers. Protective services for abused children and elders need to be better funded and staffed, and follow-up services should be expanded. Shelters and safe homes for battered women and their children must be expanded and better funded. Mechanisms to coordinate the range of services, such as legal aid, employment services, welfare assistance, day care, and counseling, should be established in every community. Mandatory arrest of abusers and greater enforcement of protection orders are important law enforcement reforms that should be expanded to more communities. There should be more research into the effectiveness of rehabilitation and prevention programs for abusers.

(2) Informed consent for interventions should be obtained from competent victims of abuse. For minors who are not deemed mature enough to give informed consent, consent for emergency interventions need not be obtained from their parents. Physicians can obtain authorization for further interventions from a court order or a court-appointed guardian.

(3) Physicians should inform parents of a child-abuse diagnosis and they should inform an elderly patient's representative when the patient clearly does not possess the capacity to make health care decisions. The safety of the child or elderly person must be ensured prior to disclosing the diagnosis when the parents or caretakers are potentially responsible for the abuse. For competent adult victims physicians must not disclose an abuse diagnosis to caregivers, spouses, or any other third party without the consent of the patient. (CEJA Rep. B, I-91; Reaffirmed: CSA Rep. 7, I-00; Modified and Reaffirmed: CEJA Rep. 1, A-03)

D-515.992 Diagnosis and Management of Family Violence

Our AMA will:

(1) urge the Agency for Healthcare Research and Quality and the National Institutes of Health to fund research on the following: (a) A national, multi-site interdisciplinary study of health care interventions that addresses the effectiveness of selected interventions for victims of family violence on improved lifetime health status, health care utilization, and a sense of safety and security. (b) Potential adverse effects of assessment for family violence on documentation and reporting to law enforcement and child-protective services. (c) Research on cost-effectiveness of health care responses to family violence. (d) Research on the primary prevention of interpersonal violence through identification and intervention of abuse across the life span;

(2) inform physicians about educational tools to aid in assessment and management of family violence, such as the Consensus Guidelines developed by the Family Violence Prevention Fund and the AMA *Roadmaps for Clinical Practice: Intimate Partner Violence* monograph; and

(3) ask the AMA Advisory Council on Violence and Abuse to study strategies for the primary prevention of family violence and inform physicians of the findings. (CSA Rep. 7, A-05)

D-515.993 Support for Legislative Action and Improved Research on the Health Response to Violence and Abuse

Our AMA, in conjunction with other members of the Federation and the National Advisory Council on Violence and Abuse will:

(1) identify and actively support state and federal legislative proposals designed to increase scientific knowledge, promote public and professional awareness, enhance recognition and ensure access to appropriate medical services for patients who have experienced violence and/or abuse; (2) actively support legislation and congressional authorizations designed to increase the nation's health care infrastructure addressing violence and abuse including proposals like the Health CARES (Child Abuse Research, Education and Services) Network; (3) actively support expanded funding for research on the primary prevention of violence and abuse, the cost of violence and abuse to the health care system, and the efficacy of interventions and methods utilized in the identification and treatment of victims of violence and abuse; (4) actively study the best practices in diagnosis and management of family violence (including an analysis of studies not reviewed in the recent US Preventive Services Task Force Recommendations on Screening for Family Violence) and present a report that identifies future research and practice recommendations; and (5)invite a Federation-wide task force to review and promote the best practices in the identification, management and prevention of family violence. (Res. 438, A-04)

D-515.996 Helping Physicians Respond to Family Violence

Our AMA will: (1) establish a committee of representatives from the National Advisory Council on Family Violence and the Council on Medical Education to include representatives from broad general membership of the AMA, including state society committees and various specialty organizations to: (a) identify the knowledge and skills needed by physicians to adequately identify, respond to and prevent violence and abuse; (b) identify recommended components for training and developing these skills within the medical education process; (c) explore the means to incorporate that training into current medical education; and (d) to establish a mechanism to respond to the anticipated proposals from the Institute of Medicine "Committee on the Training Needs of Health Care Professionals to Respond to Family Violence"; and (2) advocate for hospital and community support of violence survivor programs; (Res. 419, I-00)

E-2.02 Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse

Interpersonal violence and abuse were once thought to primarily affect specific high-risk patient populations, but it is now understood that all patients may be at risk. The complexity of the issues arising in this area requires three distinct sets of guidelines for physicians. The following guidelines address assessment, prevention, and reporting of interpersonal violence and abuse.

1. When seeking to identify and diagnose past or current experiences with violence and abuse, physicians should adhere to the following guidelines:

A. Physicians should routinely inquire about physical, sexual, and psychological abuse as part of the medical history. Physicians should also consider abuse as a factor in the presentation of medical complaints because patients’ experiences with interpersonal violence or abuse may adversely affect their health status or ability to adhere to medical recommendations.

B. Physicians should familiarize themselves with the detection of violence or abuse, the community and health care resources available to abused or vulnerable persons, and the legal requirements for reporting violence or abuse.

C. Physicians should not be influenced in the diagnosis and management of abuse by such misconceptions as the beliefs that abuse is a rare occurrence, does not occur in "normal" families, is a private problem best resolved without outside interference, or is caused by the victims own actions.

2. The following guidelines are intended to guide physicians’ efforts to address acts of violence and abuse:

A. Physicians must treat the immediate symptoms and sequelae of violence and abuse, while also providing ongoing care for patients so as to address any long-term health consequences that may arise as the result of exposure.

B. Physicians should be familiar with current information about cultural variations in response to abuse, public health measures that are effective in preventing violence and abuse, and how to work cooperatively with relevant community services. Physicians should help in developing educational resources for identifying and caring for victims. Comprehensive training in matters pertaining to violence and abuse should be required in medical school curricula and in post graduate training programs.

C. Physicians should also provide leadership in raising awareness regarding the need to assess and identify signs of abuse. By establishing guidelines and institutional policies it may be possible to reduce the volume of abuse cases that go unidentified, and consequently, help to ensure that all patients receive the benefit of appropriate assessment regardless of their age, gender, ethnicity, or social circumstances. The establishment of appropriate mechanisms should also direct physicians to external community or private resources that might be available to aid patients.

D. Physicians should support research in the prevention of violence and abuse and seek collaboration with relevant public health authorities and community organizations.

3. Physicians should comply with the following guidelines when reporting evidence of violence or abuse:

A. Physicians should familiarize themselves with any relevant reporting requirements within the jurisdiction in which they practice.

B. When a jurisdiction mandates reporting suspicion of violence and abuse, physicians should comply. However, physicians should only disclose minimal information in order to safeguard patients' privacy. Moreover, if available evidence suggests that mandatory reporting requirements are not in the best interests of patients, physicians should advocate for changes in such laws.

C. In jurisdictions where reporting suspected violence and abuse is not legally mandated, physicians should discuss the issue sensitively with the patient by first suggesting the possibility of abuse, followed by describing available safety mechanisms. Reporting when not required by law requires the informed consent of the patient. However, exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision. (I, III) Issued December 1982; Updated June 1994 based on the report "Physicians and Family Violence: Ethical Considerations," adopted December 1991 (JAMA. 1992; 267: 3190-93); updated June 1996; updated June 2000 based on the report "Domestic Violence Intervention," adopted June 1998, and updated in November 2007 based on the report "Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse."

Interpersonal Violence

H-65.974 Gender-Based Violence

Our AMA: (1) opposes inhumane treatment of people of both genders; (2) encourages the World Health Association, the World Medical Association, and other relevant organizations to continue studying and monitoring gender-based violence throughout the world; and (3) encourages the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for victims thereof. (Res. 404, A-06)

D-115.999 Domestic Violence Prevention Information and Movie Theaters

Our AMA will study the Baltimore County Medical Association's experience with their public service domestic violence awareness and referral initiative using movie theater promotions and, if appropriate, facilitate other county and state medical associations and Alliances in the implementation of similar programs by making them aware of the Baltimore programs. (Res. 419, I-99)

H-160.959 Health Care Access for the Inner-City Poor

(1) Our AMA reaffirms the following statement from Policy 140.975: "Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care."

(2) Our AMA will pursue the following initiatives to improve access to health care in the inner city: (a) Encourage the development of a congressional inner city coalition, modeled after the Rural Health Care Coalition, to move an inner-city legislative health care agenda through Congress. (b) Urge Congress to consider appropriate AMA-supported provisions from the rural health legislative agenda for application to health care services in the inner city as well; specifically those related to: (i) extension of Medicare and Medicaid bonuses to physicians practicing in medical service areas in the inner city where the poverty rate exceeds a certain threshold; (ii) expanded private and federal funding of state-of-the-art medical equipment; (iii) limited exemption for inner city physicians from federal or state antitrust or other limitations prohibiting physicians from more effectively pooling their resources and otherwise working together; (iv) tax credits for physicians practicing in underserved inner-city areas to help make up practice-related income differentials for choosing to practice in those areas; and (v) loan forgiveness for practice in underserved areas. (c) Consider the development or support of additional legislation to implement such incentives for practice in the inner city as: (i) financial assistance with start-up costs; and (ii) assistance with property and casualty insurance costs. (d) To supplement overall efforts at tort reform, continue to pursue innovative approaches for relief of professional liability costs for inner-city physicians such as: (i) payment of malpractice damages by a state or local government agency; and (ii) assistance in reducing physician costs for professional liability insurance through

payment of premiums or discounts on such premiums by a government agency. (e) Encourage appropriate funding from public and private sources for inner-city hospitals. (f) Encourage additional funding of community health resources through federal and private grants.

(3) Our AMA urges medical schools to identify, expand, and publicize the roles they play in educating students to serve the inner city poor. These included but are not limited to: (a) Recruiting more students likely to practice in the inner city; (b) Developing incentives for medical students to choose to practice in the inner city; (c) Providing exposure during undergraduate and graduate medical education to inner city practice and practice role models; and (d) Working cooperatively with community groups to develop model health care training sites in the inner city.

(4) Our AMA will encourage and where appropriate assist physicians and their local medical societies to work with teaching institutions, local health department, and community organizations in developing innovative service and financing mechanisms for delivering care in the inner city.

(5) Our AMA supports the further development of innovative, multidisciplinary approaches to delivering health care in the inner city, including use of a wide variety of health professionals under proper physician (i.e., MD/DO) supervision on a part-time or consultant basis and expanded use of physician assistants, nurse practitioners, nurse midwives, nutritionists, social workers, community outreach personnel, and lay workers.

(6) Our AMA will work to reduce the professional and personal isolation of physicians working in the inner city by encouraging: (a) Increased outreach activities and supportive interaction with such physicians by area medical schools; (b) Increased availability and use of telecommunications and on-site consultant visits from such teaching centers; (c) Practitioner linkages with the surrounding community through local customs and language training for health professionals where appropriate and the use of lay advisory committees for community clinics; and (d) Local government measures to enhance personal safety.

(7) Our AMA will stimulate more effective ways in which health education and preventive health services can be more effectively provided to and utilized by the inner-city underserved. Such services may include: (a) Immunizations; (b) Nutritional guidance; (c) Family planning; (d) Programs for prevention of sexually transmitted diseases; (e) Substance abuse programs; (f) Programs on domestic violence; (g) Education in healthy lifestyles; and (h) Parenting assistance and education.

(8) Our AMA encourages efforts to address the transportation problems that interfere with access to health care for underserved populations.

(9) Our AMA will study innovative approaches to assure patient access to prescription drugs.

(10) Our AMA will identify and publicize models of successful health care delivery for underserved populations as examples for other medical schools, physicians, and community groups.

(11) Our AMA will sponsor a national conference on access to health care for the inner-city poor.

(12) Our AMA will study and develop a plan for provision and retention of generalist physicians for service to the inner city poor. (CMS/CME Rep., I-92; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation A-01)

H-185.976 Insurance Discrimination Against Victims of Domestic Violence

Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence. (Res. 814, I-94; Appended: Res. 419, I-00)

H-515.962 Renewed Focus on Domestic Violence

Our AMA will renew its commitment to combat family and intimate partner violence by including violence prevention and education as part of the ongoing strategic planning process. (Res. 610, A-07)

D-515.990 Domestic Violence Against Pregnant Women

Our AMA will increase public awareness about domestic violence against pregnant women. (Res. 429, A-05)

Sexual Assault & Rape

H-20.900 HIV, Sexual Assault, and Violence

Our AMA:

(1) Urges that any legislative vehicle to establish a national HIV reporting mechanism include adequate safeguards to identify, screen, and protect victims of domestic violence who may either be HIV-positive or a contact of an HIV-positive individual; and

(2) Believes that HIV testing should be offered to all victims of sexual assault, that these victims should be encouraged to be retested in six months if the initial test is negative, and that strict confidentiality of test results be maintained. (CSA Rep. 4, A-03)

H-75.985 Access to Emergency Contraception

It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter. (CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04)
H-80.998 Rape Services

The AMA supports the function and efficacy of rape victim services, encourages rape crisis centers to continue working with local police to help rape victims, and encourages physicians to support the option of having a rape victim counselor present while the victim is receiving medical care. (Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-80.999 Rape Victims

Our AMA supports the preparation and dissemination of information intended to maintain and improve the skills needed by all practicing physicians involved in providing care to rape victims. (Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-515.967 Protection of the Privacy of Sexual Assault Victims

The AMA opposes the publication or broadcast of sexual assault victims' names, addresses, or likenesses without the explicit permission of the victim. (Res. 406, A-98)

H-515.968 Informing the Public & Physicians about Health Risks of Sedative Hypnotics, Especially Rohyphnol

The AMA re-emphasizes to physicians and public health officials the fact that Rohypnol (a benzodiazepine), other benzodiazepines, and other sedatives and hypnotics carry the risk of misuse, morbidity and mortality. The AMA supports public education and public health initiatives regarding the dangers of the use of sedatives and hypnotics in sexual abuse and rape, especially when mixed with ethanol ingestion. (Sub. Res. 408, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

D-430.999 Preventing Assault And Rape Of Inmates By Custodial Staff

Our AMA urges: (1) that all states have legislation that protects prisoners from sexual misconduct and assault; and (2) physicians who work within prisons to ensure procedures are followed for preventing sexual misconduct and assault of prisoners by staff and appropriately managing prisoners if abuse or assault does occur; the investigation of sexual misconduct should be confidential with information disclosed only to those individuals involved in the process. (CSA Rep. 2, I-00)

Elder Abuse

See Family Violence

War & Collective Violence

H-295.877 Medical Treatment of Prisoners of War and Detainees

Our AMA encourages medical schools to include ethics training on the issue of medical treatment of prisoners of war and detainees. (Sub. Res. 10, A-05)

H-515.964 Violence Activities

Our AMA: (1) endorses the Declaration of Washington, which urges national medical associations worldwide to promote an international ethos condemning the development, production, or use of toxins and biological agents that have no justification for peaceful purposes;

(2) specifically endorses the WHO's World Report on Violence and Health and recognizes the value of its global perspective on all forms of violence; and

(3) supports investment in primary prevention activities related to violence as well as in research and services that encourage physicians to get involved in violence prevention (e.g., detect violence among patients, advocate for legislation), and encourages the development of curricula for teaching of violence prevention in schools of medicine. (BOT Rep. 9, A-03)

D-515.994 Violence Activities

Our AMA will: (1) continue to work with interested parties to ensure the widespread dissemination and adoption of the goals outlined in the Declaration of Washington (see H-515.993), adopted by the World Medical Association last October; (2) endorse the efforts of the WHO to recognize the myriad health effects of violence on the world's citizens; and (3) work with the WHO and the WMA to disseminate the findings in the World Report on Violence and Health, working with the US Department of Health and Human Services or other governmental agencies as appropriate to make US physicians aware of the report. (BOT Rep. 9, A-03)

H-520.987 Condemning the Use of Children as Instruments of War

Our AMA: (1) condemns the use of children as instruments of war; and (2) encourages evaluation, treatment, and follow-up for children who have been used as instruments of war (Res. 411, I-01)

H-520.995 Nuclear Weapons Reduction

The AMA supports continued efforts to publicize its position that there is no adequate medical response to nuclear war. (BOT Rep. V, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CEJA Rep. 7, A-07)
H-520.997 Physician and Public Education on the Consequences of Thermonuclear Warfare

Our AMA supports: (1) informing the President and Congress of the medical consequences of nuclear war, so that policy decisions can be made with adequate factual information; (2) the preparation of appropriate informational materials to educate the physician population and the public on the medical consequences of nuclear war; (3) cooperation with responsible authorities in dealing with matters having to do with health and medical care in the event of national emergencies, including those associated with military hostility; and (4) not becoming involved in political issues outside its professional expertise, such as national defense and the politics of nuclear war preparedness, inasmuch as it is not appropriate for the AMA to do so. (BOT Rep. DD, I-81; Reaffirmed: A-83; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01)

H-520.999 Opposition to Nuclear War

The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust. (Sub. Res. 82, A-81; Reaffirmed: Sunset Report, I-98)

E-2.068 Physician Participation in Interrogation

Interrogation is defined as questioning related to law enforcement or to military and national security intelligence gathering, designed to prevent harm or danger to individuals, the public, or national security. Interrogations are distinct from questioning used by physicians to assess the physical or mental condition of an individual. To be appropriate, interrogations must avoid the use of coercion--—that is, threatening or causing harm through physical injury or mental suffering. In this Opinion, "detainee" is defined as a criminal suspect, prisoner of war, or any other individual who is being held involuntarily.

Physicians who engage in any activity that relies on their medical knowledge and skills must continue to uphold principles of medical ethics. Questions about the propriety of physician participation in interrogations and in the development of interrogation

strategies may be addressed by balancing obligations to individuals with obligations to protect third parties and the public. The further removed the physician is from direct involvement with a detainee, the more justifiable is a role serving the public interest. Applying this general approach, physician involvement with interrogations during law enforcement or intelligence gathering should be guided by the following:

(1) Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient's participation in an interrogation.

(2) Physicians must neither conduct nor directly participate in an interrogation, because a role as physician-interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.

(3) Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.

(4) Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.

(5) When physicians have reason to believe that interrogations are coercive, they must report their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations. (I, III, VII, VIII) Issued November 2006 based on the report "Physician Participation in Interrogation," adopted June 2006.

Firearms

H-145.985 Ban on Handguns and Automatic Repeating Weapons

It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to: (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers; (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 18; (c) the imposition of significant licensing fees for firearms dealers; (d) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that

are directly related to the prevention and control of violence in U.S. society; and (e) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls. (BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-145.988 AMA Campaign to Reduce Firearm Deaths

The AMA, as part of its campaign against violence, will publicize information to educate the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home. (Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03)

H-145.990 Prevention of Firearm Accidents in Children

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; and (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children. (Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00)

H-145.993 Restriction of Assault Weapons

Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon. (Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07)

H-145.994 Control of Non-Detectable Firearms

The AMA supports a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices. (Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98)

H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; and (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention. (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07)

D-145.998 Reauthorization and Strengthening of the 1994 Assault Weapons Ban

Our AMA will: (1) advocate for the renewal of the 1994 federal Assault Weapons Ban;

(2) advocate for a strengthening of the ban on assault weapons to better regulate civilian transfer and possession by:

(a) Clarifying the definition of an assault weapon to help prevent gun makers and sellers from evading the ban; (b) Banning conversion parts kits; (c) Regulating "grandfathered" assault weapons; (d) Enhanced tracing of such weapons; (e) Banning all high-capacity magazines, including imports; and (f) Prohibiting juvenile possession; and

(3) send a letter to the President, Attorney General, Surgeon General, and appropriate members of Congress indicating this strong support. (Res. 911, I-03)

D-145.999 Epidemiology of Firearm Injuries

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms; (3) assist in convening a broad-based coalition to thoroughly examine the issue of gun-

related violence from a public heath perspective; and (4) present a report of these activities to the House of Delegates at the 2003 Interim Meeting. (Res. 424, A-03)

Violence & Professionalism

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

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

H-295.912 Education of Medical Students and Residents about Domestic Violence Screening

The AMA will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient. (Res. 303, I-96; Reaffirmed: CME Rep. 2, A-06)

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 unfailing 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, gender identity, 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, gender identity, 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; Modified: BOT Rep. 11, A-07)

H-460.945 Physicians and Other Health Care Personnel as Targets of Threats, Harassment, and Violence

Our AMA will: (1) develop educational materials to assist physicians in identifying the legal options available to protect them from targeted harassment, threats, and stalking; (2) support increased national, state, and local protection for physicians and other personnel providing health care services or engaged in biomedical research; and (3) develop model state legislation that defines "stalking" as a crime, and that includes adequate provisions relating to physicians and other health care personnel. (Sub. Res. 215, I-93; Reaffirmation I-99; Reaffirmed: CME Rep. 3, A-03)

H-515.966 Violence and Abuse Prevention in the Healthcare Workplace

Our AMA encourages all healthcare facilities to adopt policies to reduce and prevent workplace violence and abuse and to develop policies to manage reported occurrences of workplace violence and abuse. (Res. 424, I-98; Reaffirmation I-99)

H-515.982 Violent Acts Against Physicians

Our AMA (1) condemns acts of violence against physicians involved in the legal practice of medicine; and (2) will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians as a result of the physician's acting in a professional capacity. (Res. 605, A-92; Reaffirmation I-99)