

Dear AMA: The Oath of Hippocrates Is Enough

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The American Medical Association is far from the arbiter of ethical behavior or the last word in medical science. Nor is the AMA the voice of physicians, given that only 15 to 18 percent of doctors in the United States are paying members of the AMA.¹ Despite its Code of Medical Ethics, the AMA's principles change with the political winds. Accordingly, the Oath of Hippocrates, not the AMA and its progeny, remains the guiding principle of medicine.

Hippocrates and the Oath

Physicians receive rigorous medical education and training that stems from the idea that physicians are compassionate critical thinkers who embrace challenges. Physicians are part detective, part counselor, and all for the patient. We have a role model: Hippocrates of Kos. Hippocrates was born in 460 B.C. and was a contemporary of the great philosophers Socrates and Plato.² He believed that diseases had natural rather than supernatural causes. Thus, he practiced the use of reason and logic rather than magic to treat diseases.

The Oath of Hippocrates, his enduring legacy, embodies the guiding ethical principles of the practice of medicine. First, the practice of medicine is a sacred and noble profession, and it is our duty to keep it so. Second, physicians must continually learn and teach their students and colleagues. Third, all of a physician's actions must be for the "benefit of the sick." And the physician "will do no harm or injustice to [the sick]" or as some translations state, "I will take care that they suffer no hurt or damage." The often quoted Latin phrase, "*Primum non nocere*" ("first, do no harm") likely originated in the 17th century. Fourth, whatever physicians see in the lives of their patients is to be kept private, or as some translations say, treated as "holy secrets." Fifth, physicians also swear on their honor "in purity and holiness" never to assist in killing a patient or providing an abortion. These duties attached whether the patients were "free or slaves."³

Carefully read, the Oath of Hippocrates covers all the bases: science, patients first, respect for life, confidentiality, and integrity—all without regard to a patient's social/racial status. And it is very clear that physicians are not meant to be generic service "providers."

Following the Science

During the COVID-19 pandemic the medical bureaucracy has told us to "follow the science." Unfortunately, the science is like Plastic Man, the superhero who could mold himself into whatever shape was needed to save the day.

The AMA's "Principles of Medical Ethics" command that "5. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical

education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated."⁴ However, the AMA has done little to scientifically address the many questions that have arisen during the COVID-19 pandemic. A full discussion regarding early treatment and a risk/benefit analysis of vaccines would assist physicians and their patients immensely in deciding on treatment choices.

PCR Test

The polymerase chain reaction (PCR) process is the standard test for a SARS-CoV-2 infection. The test multiplies the genetic material of the specimen to a cycle threshold (Ct) value. The Ct value correlates with viral load. A lower Ct value indicates a higher viral load in the sample, and vice versa.⁵ Since early 2020, routinely PCR tests were labelled positive at cycles as high as 45, yielding many false positive results. However, to label a case a "breakthrough" case, the Centers for Disease Control and Prevention (CDC) began accepting only specimens with Ct value of less than or equal to 28.⁶ The AMA's commentary on breakthrough cases ignores this laboratory diagnostic change and notes how "uncommon" such cases are.⁷

Stratified Risk

We were led to believe that everyone was equally vulnerable to developing COVID-19 after being in contact with the SARS-CoV-2 virus. Not true. The CDC's own data show that COVID-19 was the sole cause mentioned in only 6 percent of the deaths. On average there were 2.9 additional conditions or causes per death. Of course, there will be outliers, but for the most part, those who became severely ill with COVID-19 were elderly and/or had underlying medical problems.⁸

Hospitalizations and Deaths

Many times, the general public—as well as physicians who are busy seeing patients—cannot find unvarnished statistics without hours of research. The AMA has done nothing to clear up the opaqueness of the COVID-19 statistics that have given inflated numbers of hospitalizations. The statistics make no distinction between patients hospitalized for the management of COVID-19 and patients who are hospitalized and incidentally found to be infected with SARS-CoV-2 virus. The CDC guidance states that officials should report as COVID-19 deaths any in which the patient tested positive for COVID-19 or "if the circumstances are compelling within a reasonable degree of certainty" in the absence of a test. Even if a diagnosis is merely suspected, the hospital can report COVID-19 on the death certificate as "probable" or "presumed."⁹

As ethical physicians, we might see the obfuscation as a misguided attempt to encourage healthy behavior through

fear. We can only hope that the seemingly inflated numbers are not motivated by money.

Pursuant to the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), hospitals receive federal dollars for each COVID-19 patient, including 20 percent more Medicare reimbursement than for other similar care.¹⁰ The additional payment is to help hospitals offset the cost of treating patients who have COVID-19, including the purchase of necessary supplies such as personal protective equipment. This might induce a hospital to label as COVID-19 an influenza patient who may have required the same time and effort. The CDC has recorded 818,939 influenza cases for the 2020-21 flu season, in contrast to the usual 40 million cases.¹¹

Natural Immunity

We should likewise follow the science of natural post-infection immunity. Multiple studies now confirm that prior infection with the SARS-CoV-2 virus confers lasting immunity. Indeed, one study of 32,000 individuals in the community setting showed that the vaccinated were six to 13 times more likely to get infected than unvaccinated people who had previously had COVID-19. The risk of developing symptomatic COVID-19 was 27 times higher among the vaccinated, and the risk of hospitalization eight times higher.¹²

A study of Cleveland Clinic's 52,000 employees had similar findings. The reinfection rate with SARS-CoV-2 was "almost zero" among previously infected, unvaccinated persons.¹³ The immunity from an infection with the "original" SARS-CoV-2 virus appears to protect against the currently circulating Delta variant. The authors concluded that individuals who have had SARS-CoV-2 infection are unlikely to benefit from COVID-19 vaccination.

Researchers at Washington University School of Medicine in St. Louis examined the bone marrow of individuals who had had a mild case of COVID-19. They found long-lived plasma cells that produce antibodies specifically targeted to SARS-CoV-2 that would likely last a lifetime.¹⁴

Multiple other studies from top-tier researchers including the National Institutes of Health support the durability of natural immunity.¹⁵ These studies not only looked at immediate immunity but at memory B cells and T cells. One large study found that although antibodies declined over 8 months, virus-specific memory B cells increased over time, and the level of memory helper and killer T cells likely would remain steady.¹⁶ Finally, a large survey of 2002 vaccinees and a large observational study found that people with a history of SARS-CoV-2 infection experienced greater rates of side effects after vaccination.¹⁷

Unfortunately for the advancement of science and information exchange with patients and colleagues, Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases (NIAID) and chief medical adviser to the President, seems unable to answer a key question. In a Sept 10, 2021, interview, he was asked, "Why should anyone get vaccinated if they have immunity from a prior COVID infection?" His response was: "I don't have a really firm answer for you on that."¹⁸

The AMA, like Hippocrates urges scientific discussion. The AMA Code of Ethics in principle number 5 (see above) places a

duty on the physician to communicate relevant information.⁴ Yet despite these findings regarding post-infection immunity, the AMA specifically recommends that vaccination credentials not be provided on the basis of natural immunity or prior SARS-CoV-2 infection.¹⁹

Vaccine Definition

Admittedly technology changes, but the recent redefining of "vaccine" invites suspicion. The CDC's definition of vaccine has gone from "[a] product that produces immunity therefore protecting the body from the disease" in 2012 to "[a] preparation that is used to stimulate the body's immune response against diseases" as of Sept 1, 2021.²⁰ The definition of "immunity" remains the same: "Protection from an infectious disease. If you are immune to a disease, you can be exposed to it without becoming infected."²¹ So now vaccines are no longer a product that produces immunity, but rather a medication that stimulates the immune system. That is the kind of squishy language we see on supplements like astragalus root.

Just like Shakespeare's rose that by any other name would smell as sweet, what matters is what something is, not what it is called. Thus, science would dictate that a new "preparation" to stimulate the body's immune response should be called something other than a vaccine. As science and pharmaceuticals progress, we have new categories of medications and treatments. Don't manipulate. Tell it like it is. The current COVID-19 messenger RNA products are not vaccines as we know them; they are another pharmaceutical agent to lessen the symptoms of COVID-19. They are not a panacea, and they have side effects just like other therapies.

Compelled Vaccinations

Bodily autonomy is a longstanding principle of human rights and individual liberty. Whether to get a novel messenger RNA newly defined vaccine is a vexing issue for many medical professionals as well as community members. The AMA—without a discussion of the pros and cons of mass vaccination in the midst of a pandemic—has flatly recommended that physicians have their patients vaccinated. Moreover, the AMA has provided robotic messages to assist physicians in their conversations with patients.²² Examples include "Facts, logic, and compassion require us all to do our part. Get vaccinated. #COVID19" This statement is particularly ironic, given the lack of open discussion: "Vaccination and preventative measures are our best way forward. *The more information we share openly the sooner we'll get back to normal.* #VaccinesWork #COVID19 [emphasis added]"²²

More troubling is the AMA's support for "strong, universal, and enforceable federal guidelines" for the authoritarian digital vaccine credentials, fondly known as vaccine passports.¹⁹ What happened to patients' "holy secrets"?

To be fair, the AMA supported patients when this question was posed: "May a physician refuse to see an unvaccinated patient?" The response: "In general, no, a physician should not refuse a patient simply because the individual is not vaccinated or declines to be vaccinated.... A patient's vaccination status in and of itself is not sufficient reason, ethically, to turn that individual away." The AMA provided some wiggle room, recognizing the need to protect office personnel in non-

emergent situations. We must hope that the exceptions will not swallow the rule.²³

Adopting an exclusively “vaccines or bust” view is a position with which some clinicians agree. However, a quick look at the AMA’s corporate donors provides food for thought. When PhRMA is the sole “gold level” corporate donor and Abbvie, Amgen, Bristol-Myers Squibb, Eli Lilly, Genentech, GlaxoSmithKline, Henry Schein, Merck & Co., Novartis, Pfizer, Sanofi are the “silver” donors, one must wonder.²⁴ It doesn’t help the optics that Pfizer has on its board of directors Scott Gottlieb, the former Commissioner of the U.S. Food and Drug Administration (FDA).²⁵

Let’s look at the numbers. Pfizer and BioNTech are projected to sell \$40.7 billion worth of their product, and Moderna is expected to generate \$19.2 billion.²⁶ Pfizer and Moderna both have raised the price of their COVID-19 vaccines for the European Union. Pfizer will charge \$23.15 per dose and Moderna, \$25.50. Pfizer will supply 1.8 billion doses through May 2023 and Moderna plans to sell 150 million doses in 2022. Accordingly, Pfizer’s CEO in July 2021 raised its 2021 COVID-19 vaccine revenue forecast from \$26 billion to \$33.5 billion. Analysts predict Moderna could achieve from \$15 to \$30 billion in 2022 revenue. The analysts noted that the success would depend on new products such as a combination influenza and COVID-19 vaccine.²⁷

Is the AMA following the science—or keeping its benefactors happy?

“Off-Label” Medications

Prescribing a medication for a medical condition other than its FDA-approved purpose is called “off-label” prescribing. According to the Congressional Research Service (CRS) 56 percent of oncology and 12 to 38 percent of total prescriptions are written for uses not listed on the FDA-approved labeling.²⁸ Off-label prescribing is left to the judgment of the physician and is not only legal but ethical.²⁹ G. Caleb Alexander, M.D., M.S., a medical ethics advocate and assistant professor of medicine at the University of Chicago Medical Center, noted: “Off-label use is so common, that virtually every drug is used off-label in some circumstances. . . . Doctors are free to prescribe a drug for any [reason they think is medically appropriate].”³⁰

Off-label prescribing allows patients to benefit from a drug without waiting years for FDA approval. The CRS notes that off-label prescribing can reflect cutting-edge clinical expertise or a new treatment approach when other options have failed. Recognizing such benefits, the 21st Century Cures Act required the FDA to establish a program to evaluate the use of “real world evidence” to support approval of a new indication for an already approved drug.³¹

Some examples of off-label use are: (1) tamoxifen approved for breast cancer and used off label to treat infertility; (2) spironolactone, a diuretic used off label for acne vulgaris; (3) beta blockers approved for treating high blood pressure, arrhythmias, coronary artery disease, migraines, and glaucoma used off label for anxiety; and (4) statins approved to lower cholesterol and used off label to prevent heart attacks in people with diabetes.

It could not be clearer that off-label use of approved medications is an accepted and beneficial component of

medical practice. Until COVID-19, off-label prescribing had not faced particular scrutiny. Unfortunately for patients, two low-cost repurposed medications that have been prescribed for years without incident and are on the World Health Organization’s list of essential medications are being blackballed.³² The truth is, numerous studies show that when started early, hydroxychloroquine and ivermectin significantly reduce symptoms and prevent hospitalizations and deaths.

Hydroxychloroquine

Hydroxychloroquine is FDA-approved to treat or prevent malaria and autoimmune conditions such as chronic discoid lupus erythematosus, systemic lupus erythematosus in adults, and rheumatoid arthritis.³³ Despite the CDC previously acknowledging the 60-year safety record of hydroxychloroquine, it was suddenly deemed harmful in 2020 when put forth as a COVID-19 treatment.

Chloroquine was shown in vitro to have anti-viral actions against SARS-1 in 2005, and over the last 20 months hydroxychloroquine has had clinical success when used early after onset of symptoms.^{34,35} However, on Jun 15, 2020, the FDA revoked the emergency use authorization it had granted on Mar 28, 2020, to house donated chloroquine and hydroxychloroquine in the Strategic National Stockpile to be used to treat certain hospitalized patients with COVID-19 outside of a clinical trial. The FDA decided that the benefits did not outweigh any possible risks. The operative word in the revocation is “hospitalized” patients. Hydroxychloroquine’s effectiveness was shown in early outpatient treatment. While undermining the use of hydroxychloroquine, the FDA simultaneously stated, “[o]f note, FDA approved products may be prescribed by physicians for off-label uses if they determine it is appropriate for treating their patients, including during COVID.”³⁶

The AMA, rather than discuss the science, issued a joint statement with the American Pharmacists Association (APhA) and the American Society of Health-System Pharmacists (ASHP), on Mar 25, 2020. They “strongly opposed” physicians’ prescribing and dispensing hydroxychloroquine as this “can lead to supply disruptions for patients who need these medicines for chronic conditions.”³⁷ The statement suggested such prescriptions might not be for “a legitimate medical purpose.” But the AMA seemed to give a green or at least yellow light by simultaneously “encourag[ing] patient-centered care decisions, made on an individualized basis with patients’ informed consent about the risks and benefits associated with any treatment regimen.”

On Apr 21, 2020, the AMA listed hydroxychloroquine and chloroquine in a list of seven potential treatments for COVID-19.³⁸ A week later with no explanation, the AMA stated that there was “no evidence to show that hydroxychloroquine and chloroquine—prescribed for years to treat lupus and arthritis—are safe and effective for treating or preventing COVID-19.”³⁹

In late 2020, rumors circulated that the AMA “reversed course” and gave its imprimatur to the use of hydroxychloroquine to treat COVID-19. Not true. A proposal to rescind its previous position was introduced at the Oct 23, 2020, House of Delegates meeting, but it was rejected.⁴⁰

The lack of transparency and open discussion about potential treatments for a potentially deadly disease lessens the credibility of the AMA's scientific opinions.

Ivermectin

Ivermectin is an anti-parasitic approved to treat head lice, scabies, river blindness, and a variety of intestinal worms. Ivermectin has been safely used in 3.7 billion doses since 1987, well tolerated even at much greater than standard doses.⁴¹ In 2015, William Campbell and Satoshi Omura won the Nobel Prize for Physiology and Medicine for its discovery and applications.

Ivermectin appears to have a novel mechanism of action to treat breast cancer. Researchers found that ivermectin induces immunogenic cell death (ICD), a form of cell death that stimulates (rather than suppresses) the host immune system. Animal studies have shown success when used in combination with drugs that work on other cancer-inducing pathways.⁴² In these studies, 40-60 percent of animals treated with the ivermectin plus anti-PD1 antibody combination eradicated their tumors. Moreover, they were able to fight off the cancer again after it was reintroduced. (Programmed cell death protein 1 (PD-1) is an inhibitory receptor that is expressed on some tumor cells and causes down-regulation of the immune system by reducing T-cell activity. Anti-PD-1 monoclonal antibodies block the PD-1 receptor so the T cells are no longer inhibited and therefore activates the immune response against the tumor.)

Likewise, multiple studies have shown various mechanisms of action of ivermectin in treating COVID-19, including competitive binding with the SARS-CoV-2 spike protein.⁴³ India with its 1.4 billion people has had great success with ivermectin prophylaxis and post-exposure treatment. One study with medical workers found that two-dose ivermectin prophylaxis was associated with a 73 percent reduction of SARS-CoV-2 infection over the following month.⁴⁴ Additionally, the general population of India's Uttar Pradesh province greatly benefited from routine use of ivermectin in a population of more than 200 million that is only 5.8 percent vaccinated.^{45, 46}

In February 2021, the chairman of the Tokyo Medical Association, Haruo Ozaki, announced that ivermectin seems to be effective at stopping COVID-19. He publicly recommended that all doctors in Japan immediately begin using ivermectin to treat COVID. By August, Chairman Ozaki stated that despite evidence suggesting the efficacy of ivermectin, it was difficult to obtain the medication. He added that while ivermectin's established effectiveness is increasingly clear, the U.S. company that manufactures the drug, Merck & Co., Inc., has currently limited distribution, claiming that the drug is ineffective at treating COVID.⁴⁷

In a curious turn of events, on Aug 31, 2021, the AMA noted that the National Institutes of Health (NIH) concluded that evidence from clinical trials is not sufficient to "recommend either for or against the use of ivermectin for the treatment of COVID-19." [48] Nonetheless, on Sept 1, 2021, the AMA, together with APhA and ASHP, issued a statement that they **"strongly oppose the ordering, prescribing, or dispensing of ivermectin to prevent or treat COVID-19 outside of**

a clinical trial.... Patients are encouraged to talk to their physicians, pharmacists, and other prescribers about currently available therapies authorized or approved for the treatment or prevention of COVID-19.... Our organizations strongly urge eligible unvaccinated individuals to get vaccinated [emphasis in original]."⁴⁹

What happened to "advanc[ing] scientific knowledge"?

Remdesivir

Meanwhile, Dr. Fauci declared that remdesivir (Veklury®) was the standard of care despite its liver and kidney adverse side effects, high price (up to \$3,100 per treatment course), and minimal benefit.^{50, 51} Indeed, compared with the use of chloroquine, hydroxychloroquine, dexamethasone, sarilumab, or tocilizumab, the use of remdesivir was associated with increased reporting of kidney disorders.⁵² For comparison, hydroxychloroquine costs about \$40 and ivermectin \$100 per treatment course.

After remdesivir's emergency approval, studies began to emerge showing that in adult patients admitted to hospital for severe COVID-19 remdesivir was not associated with statistically significant clinical benefits.⁵³ Consequently, a few months later, WHO issued a conditional recommendation against the use of remdesivir in hospitalized patients, regardless of disease severity, "as there is currently no evidence" that remdesivir improved survival.⁵⁴

Nonetheless, NIH continues to have remdesivir on its treatment protocol.⁵⁵ Patients' families report that that is the only treatment offered.

Additionally, through the New COVID-19 Treatments Add-On Payment (NCTAP) program, Medicare will provide enhanced payment for patients with proven or suspected COVID-19 who receive certain new products: COVID-19 convalescent plasma (as of Aug 23, 2020); remdesivir (as of Oct 22, 2020); and baricitinib and remdesivir combined (as of Oct 22, 2020).⁵⁶

Quite fortuitously to rescue the future of remdesivir, Gilead, its manufacturer, released an incomplete study that found that if given early remdesivir reduced hospitalizations. The study was stopped in April 2021 because of lack of sufficient patients enrolled and the availability of monoclonal antibodies with a good record of success.⁵⁷

The COVID Double Standard

It is axiomatic that early treatment works better than late treatment for infectious processes. The CDC emphasizes that if one has the flu, one should get early antiviral treatment, noting that it works best when started within two days of getting symptoms.⁵⁸ The CDC instructs that early treatment can prevent serious flu complications, like pneumonia and "can mean the difference between having a milder illness versus a very serious illness that could result in a hospital stay."

So why ignore the merits of early treatment with off-label drugs for COVID-19? Why would the AMA tacitly agree with the perverse concept that patients should stay at home until they cannot breathe?

The AMA Code of Ethics instructs that "8. A physician shall, while caring for a patient, regard responsibility to the patient

as paramount.⁶⁴ One of the patients' rights is "(b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment."⁵⁹

With the above science and AMA positions in mind, how do we square the AMA's impassioned anti-ivermectin statement? Where were the warnings about the dangers of remdesivir?

Where is the AMA in protecting the patient-physician relationship and freedom to exchange information when it comes to COVID-19 treatments? When it comes to abortion, the AMA vociferously advocates for freedom to discuss all options with patients. "Restricting what type of information physicians may share with those whom they are trying to heal is a clear violation of patients' rights, not to mention physicians' First Amendment protections. Doing so impedes the journey to recovery and wellness."⁶⁰ In opposing restrictions on federal funding for abortions, the AMA argued that the practice of medicine will be "politicized" and "[the restrictions] will cause patients to lose faith in their providers and the health care system as a whole. It will mandate that the speech of physicians and other health care professionals be tailored according to what the government may favor, rather than according to the interests of the patient, best medical practices, or accepted medical ethics."⁶¹

In discussing transgender issues, the AMA was strident: "Decisions about medical care belong within the sanctity of the patient-physician relationship.... As with all medical interventions, physicians are guided by their ethical duty to act in the best interest of their patients and must tailor recommendations about specific interventions and the timing of those interventions to each patient's unique circumstances."⁶²

In the age of COVID-19, the AMA has changed its tune. It has ignored the wise words of Hippocrates as well as its own ethical principles, and followed the lead of the political spin doctors who relish calling ivermectin a horse dewormer.

Diversity, Equity, and Inclusion ("DEI")

The AMA was overtly on the wrong side of racial equality for years. As far back as 1847, the AMA supported the exclusion of black physicians from medical societies and disparaged the abilities of black and female physicians. Nor did the AMA speak up during the dreadful eugenics movement, forced sterilizations, and the grossly unethical Tuskegee syphilis experiments.

There is no question that there are racial disparities in many aspects of life in the United States, including medical care. The root causes for such disparities can be elusive and have been the topic of years-long, intense debates.

In 2008, the AMA publicly apologized for its past racist sins. Now it has chosen the politically fashionable side of the debate and embraced the concept that the United States is systemically racist. That is, its institutions, laws, economic system, science, and standardized tests are racist and that

racism is not explained by private prejudices. This view leaves little room for introspection into one's personal attitudes and behavior.

The AMA believes it is going to do its part in dismantling systemic racism in medicine with its "Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity 2021-2023."⁶³ According to the document, whose language mirrors that of critical race theory, "race was manufactured by humans...and has been consistently used to legitimize the preferential treatment of whites over others."⁶³ Further, social definitions of race differ depending on context, but they "always operate in the service and self-interests of social-dominance hierarchies, thus benefitting white individuals."⁶³ The document instructs that we must "work through the trappings of white supremacy."⁶³ One tool is to expand medical school and physician education to include "equity, anti-racism, structural competency, public health and social sciences, critical race theory and historical basis of disease."⁶³

The plan seeks to excise "the myth of meritocracy." One goal is to prevent exclusion of and ensure "just representation of Black, Indigenous and Latinx people in medical school admissions as well as medical school and hospital leadership ranks."⁶³ Students, also known as BIPOCs (Black, Indigenous, People of Color) now get yet another segregating label: URM (Underrepresented Minorities).

The question of whether we are to lower academic standards to broaden the pool of minority students has plagued admissions offices for decades. Turning our backs on science and a rigorous education is not the answer. This will only feed into the idea that physicians of color are substandard—a notion that we minority physicians have disproved for years. How? By holding to high education standards and being good at our profession. As members of the community, physicians should be actively involved in finding strategies to improve early education where reform will have the largest and long-lasting effect. At an early age, we should teach black excellence and achievement, not victimhood and oppression.

The answer for engaging white physicians is not 86 pages of self-flagellation interlaced with pseudo-intellectual gobbledygook, such as "innovation ecosystem," "invisible-ized," "minoritized," and "anti-racist praxis" fit for a college term paper. The AMA should repent for its sins but it need not speak for physicians who have been practicing medicine in the tradition of Hippocrates and have treated all their patients with the respect each human being deserves.

Equity plans and lectures from consultants likely will not transform a jester into a prince. All but a few misguided boors want to treat people fairly. Perhaps some do not know how to relate to people with different life experiences. Most are willing to learn. Subjecting them to public humiliation and degradation because of the color of their skin is not going to impart a positive and cooperative attitude. A "human to human" approach might be a more effective path to developing trusted relationships with patients and colleagues.⁶⁴⁻⁶⁶ We can work to understand and heal differences by being open with our patients and admit areas of ignorance and concern. Patients will appreciate the honesty and forgive social missteps. Patients will then feel they can do likewise. Hippocrates would approve if "DEI" represented dignity, equality, and integrity.

I am compelled to note that there is one area where black Americans are way ahead of the curve. Non-Hispanic black women (13 percent of women) accounted for 33.6 percent of abortions in contrast to non-Hispanic white women (64 percent of women), who accounted for 38.7 percent.⁶⁷ If the AMA wanted to improve the humanity and health of black individuals, it might consider remedying its position on this horrific racial inequity. Of course, history reveals that the AMA's opposition to abortion in the 19th century did not derive from a respect for human life. Because midwives and other "irregulars" performed abortions, the AMA initiated its anti-abortion stance as a means to enhance physicians' professional standing.⁶⁸ What happened? The AMA was swept up by shifting political winds.

Conclusion

The American Medical Association is far from an organization of creative, critical thinkers who provide us with non-political, honest, and scientific discussion. The AMA comes across as a government mouthpiece.

Physicians true to their Oath of Hippocrates will continue to advocate for a culture of respect for all human life. In our world of changing cultural norms, Hippocratic medical ethics, centered on the sanctity of the patient-physician relationship, is immutable and should suffice.

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