

Subject: AMA-RFS Organizational Report
Informational Report

Introduced by: RFS Governing Council

1
2 **Career Resources**
3

4 **Succeeding from medical school to practice—a three-part guide:** This comprehensive,
5 on-line resource includes a wealth of advice plus streaming video to help medical students,
6 residents, fellows and young physicians confront the nonclinical demands of training and
7 today's practice environment. Developed by your AMA physician colleagues, this guide offers
8 AMA members the tools needed to succeed at every stage of their career: [http://www.ama-](http://www.ama-
9 assn.org/go/succeeding)

10
11 **Medical school and residency:** Addressing the first major transition point of a
12 physician-in-training, this section helps you answer important questions about:

- 13 • How to prepare for the match
- 14 • What are the duty hour standards and how
- 15 • to deal with violations
- 16 • What are the requirements for board certification
- 17 • How is medical education funded
- 18 • How to take advantage of foreign residency rotations
- 19 • How to budget and manage personal finances

20
21 **Preparing for practice:** This section prepares you with resources such as:

- 22 • How to get credentialed and obtain hospital privileges
- 23 • Weighing your options—medical practice start-up, purchase or buy-in
- 24 • What to look for in medical liability and disability insurance policies
- 25 • What does physician profiling mean to you
- 26 • What to consider in selecting a practice setting and geographical location

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28 **Joining, purchasing or starting a practice:** Once you've decided to join, purchase or
29 start a practice, this section will take you through your next steps including:

- 30 • How to negotiate an employment contract
- 31 • How to value a medical practice for purchase or buy-in
- 32 • How to set up and market a practice
- 33 • How to deal with the challenges of managed care

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35 **FREIDA Online** – A database with over 8,400 graduate medical education
36 programs accredited by the Accreditation Council for Graduate Medical Education and ABMS
37 Board-approved combined specialty programs. [http://www.ama-](http://www.ama-
38 assn.org/ama/pub/category/2997.html)
39

1 **Improving working conditions** – Learn about duty hour guidelines, reporting duty hour
2 violations, Graduate Medical Education funding, resident income and debt relief, physician
3 recruiters and much more. <http://www.ama-assn.org/ama/pub/category/175.html>
4

5 **Foreign residency rotations and opportunities abroad** – The AMA-RFS is committed to
6 informing medical student and resident/fellow members about opportunities to expand their
7 medical experience through international electives. Foreign residency rotations enable
8 resident physicians to become immersed not only in different modalities of medical care, but in
9 the culture and traditions of each respective country as well. [http://www.ama-](http://www.ama-assn.org/ama/pub/category/12557.html)
10 [assn.org/ama/pub/category/12557.html](http://www.ama-assn.org/ama/pub/category/12557.html)
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12 **General Benefits and RFS Communications**

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15 **Receive a free AMA physician recognition award certificate** – AMA resident members who
16 have completed one to three years of residency can receive an AMA Physician's Recognition
17 Award (PRA) certificate at no charge as a benefit of AMA membership (\$58 for nonmembers).
18 The certificate is accepted by many state licensing boards, hospitals and other professional
19 medical organizations as evidence of meeting continuing medical education (CME)
20 requirements. Thirty-eight states and territories accept the PRA certificate in lieu of CME
21 requirements for your license registration. [http://www.ama-](http://www.ama-assn.org/ama/pub/category/5754.html)
22 [assn.org/ama/pub/category/5754.html](http://www.ama-assn.org/ama/pub/category/5754.html)
23

24 **Public health resources** – Covers a variety of important topics, including health disparities,
25 disaster response, obesity assessment and management, infectious disease, adolescent
26 health, dementia, geriatrics, etc. <http://www.ama-assn.org/ama/pub/category/7092.html>
27

28 **Resident and fellow section listserv** – Stay informed of all advocacy initiatives, awards,
29 grants, internships, and leadership opportunities. [http://www.ama-](http://www.ama-assn.org/ama/pub/category/7091.html)
30 [assn.org/ama/pub/category/7091.html](http://www.ama-assn.org/ama/pub/category/7091.html)
31

32 **Resident and fellow publications** – Read up on issues that are written by and important to
33 residents and fellows. <http://www.ama-assn.org/ama/pub/category/17544.html>
34

35 **GME e-Letter** – This free monthly e-mail newsletter, covering a wide range of issues affecting
36 graduate medical education, is a popular source of news and information for its 14,000
37 readers. <http://www.ama-assn.org/go/gmenews>
38

39 **Award, Grant and Internship Opportunities**

40 <http://www.ama-assn.org/ama/pub/category/5754.html>
41

42
43 **Legislative Awareness Internship Program** – The AMA-RFS Legislative Awareness
44 Internship Program offers residents and fellows the opportunity to participate in the political
45 process of organized medicine at the national level. Two residents/fellows are selected to
46 participate in a two-week internship at the AMA's Washington, DC office. A \$1,000 stipend is
47 offered to help defray costs.
48

49 **Discovery Health Internship** – The AMA-RFS and Discovery Health select one
50 resident/fellow for a communication rotation to develop health-related programming for the
51 Discovery Channel. A \$3,000 stipend is offered to help defray costs.
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1 **Research Seed Program** – The AMA Foundation is offering Research Seed Program grants
2 of \$1,500 to \$2,500 to residents and medical students to help conduct small projects in applied
3 and clinical research in areas such as adolescent health, animal use in research,
4 arthritis/rheumatism, HIV/AIDS, cardio-pulmonary, endocrine, neoplastic, and psychiatric
5 disease.

6
7 **AMA-RFS Research Poster Symposium** – The Symposium is designed to give trainees the
8 opportunity to display their original work among peers and compete for cash prizes. Abstracts
9 may be submitted for poster presentation in one of four categories: clinical medicine, basic
10 science, medical education or health policy, and clinical vignettes.

11
12 **Seeking public office? AMPAC political education programs can help** – The Candidate
13 Workshop and Campaign School, held for over 20 years, provide unmatched political training
14 for physicians and other friends of medicine who are interested in either seeking public
15 office themselves or in working to elect other friends of medicine.

16
17 **Jordan Fieldman Award** – The AMA-RFS offers the Jordan Fieldman Award to a first time
18 delegate or attendee who seeks future participation in the RFS, enthusiastically endorses the
19 ideals of advocacy and activism as exemplified by Dr. Fieldman, and possesses meritorious
20 qualifications and the highest level of moral character. This award funds the awardee's travel
21 and attendance to the Annual and Interim Meetings.

22
23 **Paul Ambrose Award for Leadership Among Resident Physicians** – Dr. Paul Ambrose
24 dedicated his career to improving the health of the public and to increasing physician
25 leadership in health policy. His dedication and commitment to medicine continue through this
26 leadership award, which recognizes and encourages excellence in leadership development
27 within public health by residents and fellows and serves to stimulate similar efforts by other
28 physicians in training. This award funds the awardee's travel and attendance to the Annual
29 and Interim Meetings.

30
31 **Foundation Leadership Award** – The AMA Foundation Leadership Award recognizes the
32 leadership potential of residents and fellows, medical students, and young physicians based
33 on their non-clinical leadership experience in medical arenas, civic organizations and
34 community service organizations. Award recipients receive travel, hotel accommodations, and
35 registration for the AMA's National Advocacy Conference in Washington, DC.

36
37 **Policy Promotion Grant Program** – The program awards grants of up to \$500 to residents
38 and fellows to aid with projects and activities that promote or encourage AMA policy..
39
40

41 ***Leadership Development***

42 <http://www.ama-assn.org/ama/pub/category/189.html>

43
44 **AMA-RFS Governing Council** – The Governing Council is composed of seven residents and
45 fellows who meet four times a year to establish the Section's work plan, implement policy
46 initiatives, and establish programming for the Assembly meetings.

47
48 **AMA-RFS Assembly Meetings** – The Section has two Assembly meetings per year in which
49 policies are debated and established. The Assembly consists of 150 resident/fellow delegates
50 from state and specialty associations from around the country.
51

1 **Sectional Delegate and Alternate Delegate Positions** – RFS Sectional Delegates and
2 Alternate Delegates are given full voting privileges in the AMA House of Delegates (HOD).
3 Responsibilities include caucusing with your endorsing society, assisting the RFS Delegate
4 and Alternate in representing the Resident and Fellow members of the AMA in the HOD,
5 and reporting back to the resident and fellow section of their state or specialty endorsing
6 society regarding the activities of the AMA HOD. For 2009, there are 14 Sectional Delegate
7 and 14 Sectional Alternate Delegate positions available. The term is one year.

8
9 **Standing Committees** – The RFS has several standing committees for members to join. The
10 committees deal with issues such as membership, grassroots advocacy and legislative efforts,
11 educational initiatives, public health issues, the poster symposium and long range planning.

12
13 **Initiative to Transform Medical Education** – For the past two years, the American Medical
14 Association has been engaged in a collaborative effort titled the Initiative to Transform Medical
15 Education (ITME). ITME’s goal is to “promote excellence in patient care by implementing
16 reform in the medical education and training system across the continuum, from premedical
17 preparation and medical school admission through continuing physician professional
18 development.” To date, ITME has identified gaps and areas for improvement in the system of
19 medical education and has created recommendations to address these gaps (visit
20 <http://www.ama-assn.org/ama1/pub/upload/mm/377/finalitme.pdf> to view ITME June 2007
21 report).

22
23 **Medical Student/Resident Lobby Day** – Each year the AMA offers AMA-RFS members the
24 opportunity to influence federal lawmakers by participating in Student/Resident Lobby Day
25 during the National Advocacy Conference (NAC) in Washington, DC. Students and residents
26 meet with senators, representatives and legislative staff to discuss issues affecting medical
27 education and the way they will practice medicine in the future.

28
29 **Additional leadership positions** – The AMA-RFS Governing Council solicits nominations for
30 more than 20 leadership positions for resident and fellow physicians, including the National
31 Resident Matching Program, Council on Medical Education, Council on Science and Public
32 Health, Accreditation Council for Graduate Medical Education, and many more.

33
34 If you have questions or would like additional information, please contact members of the RFS
35 Governing Council or RFS staff at (312) 464-4978.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: B
(I-08)

Introduced by: AMA-RFS Governing Council

Subject: AMA-RFS Issues Update

1 *Advocacy*

2
3 **Medicare Physician Payment**

4 Despite a presidential veto, H.R. 6331, the “Medicare Improvements for Patients and Providers
5 Act of 2008,” passed with wide, bi-partisan majorities in both the U.S. House of Representatives
6 and the U.S. Senate. This bill, which became law, replaces the 10.6% payment cut that went
7 into effect on July 1, 2008 with a 0.5% update extension through December 31, 2008. For
8 calendar year 2009, the update will be 1.1%. This 18-month reprieve will also provide time for
9 Congress to work with physicians on developing a long-term solution to a payment system that
10 all agree is fatally flawed. For highlights of this legislation and additional information, visit
11 <http://www.ama-assn.org/ama/pub/category/6583.html>
12

13 **National Health Insurer Report Card**

14 The AMA's new National Health Insurer Report Card provides physicians and the public with an
15 objective and reliable source of information on the timeliness, transparency and accuracy of
16 claims processing by health insurance companies. Based on a random-sample pulled from
17 more than 5 million electronically billed services, the report card provides an in-depth look at the
18 claims processing performance of Medicare and seven national commercial health insurers:
19 Aetna, Anthem Blue Cross Blue Shield, CIGNA, Coventry Health Care, Health Net, Humana
20 and United Healthcare. The report card demonstrates the inconsistency and confusion that
21 results from each health insurer using different rules for processing and paying medical claims.
22 This variability requires physicians to maintain a costly claims management system for each
23 health insurer. The report card also suggests that both physicians and health insurers can help
24 reduce unnecessary administrative costs if electronic transactions and full transparency are
25 widely adopted. The costs of re-submitting claims can also be reduced if health insurers make
26 better use of voluntary fields and reason and remark codes in electronic transactions to
27 communicate crucial information to physicians about their claims. For detailed information and
28 to view the report card, visit <http://www.ama-assn.org/ama/pub/category/18660.html>
29

30 **Student Loan Deferment Provisions**

31 The federal government has recently made significant changes to the laws pertaining to the
32 repayment of medical education loans during residency. The AMA is working to preserve the
33 20/220 pathway for economic hardship deferment. The AMA supports bills currently pending in
34 both houses, S. 2303 and H.R. 4344, that would permanently restore the 20/220 pathway, a
35 loan deferment program for eligible medical residents. You can help by using an AMA call-in
36 **Script** and the **AMA Capwiz site** to send Congressional members a message in support of the
37 20/220 pathway! For links to these site and up-to-date information on how these changes may
38 affect you, visit www.ama-assn.org/go/loandeferment.
39

40 **The FICA Student Exemption Issue**

41 Often schools, colleges and universities employ students on a part-time or intermittent basis.
42 Income or stipends received may be exempt from withholding of FICA taxes if the so-called

1 “student exemption” applies. For years, the IRS has contended that medical students and
2 residents can never be exempt from FICA, now courts in several cases have ruled they **may or**
3 **do qualify** for the statutory “student exemption” from FICA, depending upon the facts. For
4 background, historical analysis, and details on how this may affect you, read the RFS briefing
5 document at http://www.ama-assn.org/ama1/pub/upload/mm/16/fica_briefing.pdf
6

7 On Sept. 23, 2008, a federal appeals court ruled that medical residents are not categorically
8 excluded from claiming exemption from payment of employment taxes under the Federal
9 Insurance Contribution Act (FICA) (*University of Chicago Hospitals v. United States*, 7th Cir., No.
10 07-1838). The court joined a series of recent district and circuit courts when it rejected the
11 government’s argument that medical residents are not eligible for a student exemption under
12 Internal Revenue Code Section 3121(b)(10), holding instead that a case-by-case analysis is
13 required to determine whether medical residents serving specific institutions qualify for the
14 exemption. The court further added that medical school graduates participating in postgraduate
15 medical residencies at university hospitals may be regarded as students within the meaning of
16 the statute.
17

18 **AMA's Campaign for the Uninsured**

19 The AMA’s Voice for the Uninsured campaign is a three-year effort to spur action to cover
20 America’s uninsured. The campaign’s advertisements feature physicians and uninsured
21 patients, and focus on the AMA’s efforts to find a solution. The Section is proud that Fellow and
22 AMA Trustee Samantha L. Rosman, MD is in the forefront of the campaign, which was launched
23 in August, 2007. The advertisements have been seen in city airports and on rail transportation,
24 buses, taxi tops, and billboards. Print and online advertisements have run in national and
25 medical trade publications including Time, Newsweek, Modern Healthcare and Medical
26 Economics and on news sites including CNN.com, AOL.com, FoxNews.com, New
27 YorkTimes.com, and USA Today.com. To view the ads, send a letter to Congress, or share your
28 voice visit the updated Web site, www.voicefortheuninsured.org.
29

30 **Physician Recruiters**

31 Since residents and fellows raised concern about unsolicited pages from recruiters disrupting
32 training and patient care throughout the work day, the RFS had lead the fight to end this
33 practice. Several letters have been written by the AMA urging the National Association of
34 Physician Recruiters to implement ethical guidelines that will end this practice. The AMA has
35 also written a letter to program directors asking for their help with this problem. Additionally,
36 RFS staff has followed up on resident complaints of unethical recruiting practices. For more
37 information visit <http://www.ama-assn.org/ama/pub/category/7092.html>.
38

39 **Elimination of Benefit Waiting Periods for Residents and Fellows**

40 A resident wrote a resolution asking that discrepancies between Graduate Medical Education
41 (GME) training institutions in the provision of healthcare, dental care, vision care, life, and
42 disability insurance be eliminated. Although the majority of GME training institutions were
43 providing benefits to physician trainees on the first day of employment, some institutions were
44 imposing 60-90 day waiting period, which put the health and financial stability of new residents a
45 risk. After the resolution was considered and adopted, the AMA worked with the ACGME to
46 amend institutional requirements so that benefits now start on the first day for all residents and
47 their families. This is an example of how one AMA resident member can make a difference and
48 improve the quality of life for thousands of current and future physicians-in-training. To read
49 more about this issue, visit <http://www.ama-assn.org/ama/pub/category/15732.html>
50
51

1 **ACGME Duty Hour Violations**

2 A productive and sustainable working environment that is conducive to professional
3 development and the safe delivery of patient care remains the highest priority of your RFS. The
4 following document, created by your RFS, tells you how to report duty hour violations to
5 ACGME and points to consider when submitting your formal complaint: [http://www.ama-](http://www.ama-assn.org/ama1/pub/upload/mm/16/acgme_complaint.pdf)
6 [assn.org/ama1/pub/upload/mm/16/acgme_complaint.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/16/acgme_complaint.pdf)
7

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9 *Education*

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11 **U.S. Presidential Candidate Health Plans**

12 The AMA is pleased to see the presidential candidates making health care a top priority. Listed
13 below are the key advocacy priorities of the AMA, along with links to the Web sites of each
14 declared candidate. Review the key advocacy priorities of the AMA and evaluate the proposals
15 and platforms of the presidential candidates at [http://www.ama-](http://www.ama-assn.org/ama/pub/category/18051.html)
16 [assn.org/ama/pub/category/18051.html](http://www.ama-assn.org/ama/pub/category/18051.html)
17

18 **Educational Sessions at I-08**

19 On the heels of the U.S. Presidential election, your 2008-2009 AMA-RFS Governing Council
20 has organized a series of educational sessions to empower you with essential leadership skills
21 and an understanding of the U.S. political process. Join your physician colleagues on **Sat.,**
22 **Nov. 8** in the RFS Assembly room to attend the following sessions:
23

24 **On Leadership:** 12:00 - 1:00 pm
25 Speaker: Donald J. Palmisano, MD, JD
26

27 **Overview of the Political Environment:** 1:05 - 1:50 pm
28 Speaker: Alex Calcagno, Director of Federal Relations, Massachusetts Medical Society
29

30 **How to Run a Political Campaign:** 2:00 - 2:45 pm
31 Speaker: Michael Katz, MD, Delaware State Senate Candidate

AMERICAN MEDICAL ASSOCIATION-RESIDENT AND FELLOW SECTION

Report: C
(I-08)

Subject: AMA-RFS Sunset Mechanism: 1998 Actions to Reaffirm
Action Report

Introduced by: RFS Governing Council

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2 At the 1985 Interim Meeting, the American Medical Association-Resident and Fellow Section
3 (AMA-RFS) Assembly adopted Report H, "Sunset of AMA-RFS Policy." Report H established a
4 mechanism to systematically review AMA-RFS actions ten years after their adoption. The process
5 specifies that an informational report be prepared for the Annual Meeting, with final
6 recommendations considered at the Interim Meeting.

7
8 The sunset mechanism for the AMA-RFS actions was established to identify and rescind
9 outmoded, irrelevant, duplicative, or inconsistent actions. This report contains a list of the actions
10 adopted by the AMA-RFS Assembly that are recommended for reaffirmation. A complete
11 description of these actions is included.

12
13 **1998 AMA-RFS Actions Recommended for Reaffirmation:**

- 14
15 100.995R Regulation of Herbal Preparations
16 160.999R National Health Issues
17 255.999R Non-Discriminatory Residency Policy
18 275.994R USMLE Step 3 and Initial Licensure Fees
19 295.997R Clinical Skills Assessment
20 305.887R Public Disclosure of Residency Revenue and Expenditures
21 305.990R Student Debt and Post 1986 Tax Changes
22 310.588R Support for Night Float Rotation
23 310.791R Annual Contracts for Continuing Residents
24 310.792R Collective Negotiations by Residents (Part 1)
25 310.890R Training in Reimbursement Coding in Residency Programs
26 310.899R Cardiopulmonary Resuscitation Certification for Residents and Other Physicians
27 325.998R Resident Participation in Specialty Societies
28 325.999R Submitting Annual Reports
29 330.998R Payment for Federally Mandated Emergency Care
30 405.992R Physician Diversity
31 420.998R Guidelines on the Protection of Pregnant Health Care Workers and Their Fetuses From
32 Exposure to Potential Infectious/Teratogenic Agents
33 440.988R National Standardization of Preparticipation Screening and Examination of High
34 School Athletes
35 440.989R Chlamydia Trachomatis as a Reportable Disease
36 440.990R Increasing Antibiotic Resident Bacteria Awareness
37 505.994R Bring Back the Extinguisher
38 630.991R Providing Financial Information to Residents
39 630.999R Fiscal Affairs of the Resident and Fellow Section
40 635.995R Resident Representation on the Internal Medicine Residency Review Committee:

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2 **Appendix I: Statement of AMA-RFS Policy**
3

4 **100.995R** Regulation of Herbal Preparations: Asked that the AMA advocate modification of the
5 Dietary Supplement Health and Education Act (DSHEA) to require that dietary
6 supplements, in order to be marketed: (1) undergo Food and Drug Administration
7 (FDA) pre-approval for evidence of safety; (2) meet criteria established by the United
8 States Pharmacopoeia (USP) for dosage, quality, purity, packaging, and labeling; (3)
9 meet FDA post marketing requirements to report adverse side effects, including drug
10 interactions and that the AMA encourage efficacy studies on dietary supplements.
11 (RFS Substitute Resolution 11, I-98)
12

13 **160.999R** National Health Issues: Asked that the Governing Council continue to review national
14 health issues and ways in which the AMA-RFS could influence these issues, and
15 report to the AMA-RFS Assembly as appropriate. (RFS Resolution 19, A-78;
16 Reaffirmed: Report C, I-88; Reaffirmed: RFS Report C, I-98)
17

18 **255.999R** Non-Discriminatory Residency Policy: Asked that the AMA-RFS oppose
19 discrimination in residency applications based solely on country of medical school
20 training. (RFS Substitute Resolution 3, I-88; Reaffirmed: RFS Report C, I-98;) [See
21 also: AMA Policy H-255.992]
22

23 **275.994R** USMLE Step 3 and Initial Licensure Fees: Asked the AMA to encourage state
24 medical societies to advocate to the state legislatures and medical licensing boards that
25 the total fees required when a resident registers for the USMLE Step 3, including any
26 required licensure fees, be kept at a moderate level. Also asked the AMA to
27 investigate the costs involved in administering the USMLE, including any future
28 computerized version and encourage minimization of the costs to physicians in
29 training. (RFS Report G, A-98)
30

31 **295.997R** Clinical Skills Assessment: Asked that the AMA-RFS ask the LCME and the
32 American Osteopathic Association to ensure that all LCME and AMA accredited
33 medical schools comply with the requirement that schools teach and assess clinical
34 schools. Also asked that the AMA explore ways to make the Clinical Skills
35 Assessment examination more accessible to International Medical Graduates. (RFS
36 Substitute Resolution 6, A-98)
37

38 **305.887R** Public Disclosure of Residency Revenue and Expenditures: Asked (1) that the RFS
39 Governing Council study the feasibility of residency programs obtaining and
40 disclosing revenues and expenditures related to residency training; (2) that the RFS
41 Governing Council report to the RFS Assembly at A-99 on current and proposed
42 methodologies of Medicare GME funding; and (3) that the RFS report to the
43 Assembly on the feasibility of developing accounting techniques to report the
44 annualized value of resident services. (RFS Substitute Resolution 2, I-98)
45

46 **305.990R** Student Debt and Post 1986 Tax Changes: Asked the AMA to continue to recognize
47 the seriousness of the problem of the expanding burden of medical education debt and
48 elevate to a top legislative priority. Also asked the AMA to collaborate with other
49 medical and professional associations to seek sponsorship and support passage of
50 legislation consistent with current AMA policy that would return to the pre-1986 tax
51 status for interest on education related debt. (RFS Resolution 8, A-98)

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310.588R Support for Night Float Rotation: Asked that the AMA encourage alternatives to the traditional night call system in undergraduate and graduate medical education training to support the elimination of any RRC guidelines that discourage alternatives to traditional night call such as night float. (RFS Substitute Resolution 10, A-98)

310.791R Annual Contracts for Continuing Residents: Asked that the AMA urge the ACGME to require residency programs to provide their continuing residents with an annual written contract no later than March 1. (RFS Substitute Resolution 12, I-98)

310.792R Collective Negotiations by Residents: Asked 1) that the AMA ask its representatives to the ACGME to continue their diligence in supporting inclusion of the following AMA proposed amended language into Section 1,B,3,e(1) of ACGME's Institutional Requirements:

Section 1,B,3,e(1) Provision of an organization system for communication and resolution of resident concerns on all issues pertaining to resident educational programs, patient care and resident well being. Institutions must allow resident physicians the ability to form a resident organization and use it or other forums to facilitate regular assessment of resident concerns. (RFS Report F, A-98)

310.890R Training in Reimbursement Coding in Residency Programs: Asked that the AMA encourage training in practice management, including training on proper reimbursement coding and documentation to better prepare residents for medical practice. (RFS Substitute Resolution 3, A-98)

310.899R Cardiopulmonary Resuscitation Certification for Residents and Other Physicians: Asked that the AMA-RFS support competency in basic CPR during residency training. (RFS Substitute Resolution 13, I-78; Reaffirmed: RFS Report C, I-88; Reaffirmed: RFS Report C, I-98) [See also: AMA Policy H-130.997]

325.998R Resident Participation in Specialty Societies: Asked that the (1) AMA and AMA-RFS encourage national medical specialty societies to foster resident physician membership and participation in their policy formulation and leadership development; and (2) AMA-RFS continue to encourage the development of resident physicians sections among national medical specialty societies. (RFS Substitute Resolution 10, A-88; Reaffirmed: RFS Report C, I-98) [See also: AMA Policy H-325.990]

325.999R Submitting Annual Reports: That the AMA-RFS suggest that (1) annual reports be submitted by each state and specialty resident physicians section prior to the Annual Meeting of the AMA-RFS Assembly for distribution at the meeting; and (2) these reports be brief (up to one page) and include a listing of officers and delegates and their method of selection and a brief summary of accomplishments, projects, special concerns and any specific goals for the coming year. (RFS Substitute Resolution 23, I-88; Reaffirmed: RFS Report C, I-98)

330.998R Payment for Federally Mandated Emergency Care: Asked that the AMA actively advocate to HCFA and the Congress that an equitable adjustment to the medical physician fee schedule be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with EMTALA. (RFS Emergency Resolution 1, A-98)

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405.992R Physician Diversity: Asked that the AMA-RFS support AMA policies 350.988, 350.991, 350.993, and 350.995 which encourage increased representation by minorities in medicine. (RFS Substitute Resolution 7, A-98)

420.998R Guidelines on the Protection of Pregnant Health Care Workers and Their Fetuses From Exposure to Potential Infectious/Teratogenic Agents: Asked that the AMA-RFS support the development of scientifically based safety guidelines to protect pregnant workers and their fetuses from hazardous exposure to infectious/teratogenic agents in the healthcare workplace. (RFS Substitute Resolution 15, I-98)

440.988R National Standardization of Preparticipation Screening and Examination of High School Athletes: Asked that the AMA encourage dissemination of current American Heart Association guidelines regarding pre-participation screening and examination of high school athletes. (RFS Substitute Resolution 16, I-98)

440.989R Chlamydia Trachomatis as a Reportable Disease: Asked the AMA to encourage state health departments to follow-up on patients testing positive for Chlamydia Trachomatis by notifying the patients and their potential contacts of methods to reduce or avoid their chances of infection, reinfection or to avoid the progression of the disease. (RFS Substitute Resolution 15, A-98) [See also AMA Policy H-440.900]

440.990R Increasing Antibiotic Resident Bacteria Awareness: Asked that the AMA encourage the appropriate healthcare agencies to increase public education about the judicious use of antibiotics and the dangers of antibiotic resistant pathogens. (RFS Substitute Resolution 14, A-98) [See also AMA Policy H-100.973]

505.994R Bring Back the Extinguisher: Asked that the AMA immediately restore funding for “The Extinguisher” anti-tobacco program and that the resolution be forwarded to the AMA-HOD for consideration at A-98. (RFS Substitute Resolution 4, A-98)

630.991R Providing Financial Information to Residents: Asked that the RFS include information on financial products and services offered by the AMA to residents in its Student Loan Manager Booklet. (RFS Substitute Resolution 9, A-98)

630.999R Fiscal Affairs of the Resident and Fellow Section: Asked the Governing Council to provide an annual fiscal report for the previous year at the Annual Meeting. (RFS Substitute Resolution 18, A-78; Reaffirmed: RFS Report C, I-88; Reaffirmed: RFS Report C, I-98)

635.995R Resident Representation on the Internal Medicine Residency Review Committee: Asked that the AMA request all Residency Review Committees utilize peer-selected resident representatives to serve as voting members at all meetings of the committee for at least a one year term preceded by a six month term as an observer. (RFS Substitute Resolution 2, A-98)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: D
(I-08)

Subject: AMA-RFS Sunset Mechanism: 1998 Actions to Rescind
Action Report

Introduced by: RFS Governing Council

At the 1985 Interim Meeting, the American Medical Association-Resident and Fellow Section (AMA-RFS) Assembly adopted Report H, "Sunset of AMA-RFS Policy." Report H established a mechanism to systematically review AMA-RFS actions ten years after their adoption. The process specifies that an informational report be prepared for the Annual Meeting, with final recommendations considered at the Interim Meeting.

The sunset mechanism for the AMA-RFS actions was established to identify and rescind outmoded, irrelevant, duplicative, or inconsistent actions. This report contains a list of the actions adopted by the AMA-RFS Assembly that are recommended for rescission. A complete description of these actions is included.

1998 AMA-RFS Actions Recommended for Rescission:

- 200.990R Opposition to Medical Staff Development Plans
- 275.997R Postgraduate Training Requirements for Obtaining Permanent Medical Licensure
- 305.991R Use of Social Security Numbers on Student Loan Accounts
- 310.587R Data Bank for Poor Outcomes Associated with Excessive Work Hours
- 310.792R Collective Negotiations by Residents (Parts 2 and 3)
- 405.991R Physician in the Capitol/Statehouse Program
- 405.989R The Disruptive Physician

Appendix I: Statement of AMA-RFS Policy

200.990R Opposition to Medical Staff Development Plans: Asked that the RFS Governing Council study Board of Trustees Report 14 (A-98), Medical Staff Development Plans, and the consequences of these plans on residents and young physicians and, if necessary, make recommendations for action at I-98. (RFS Substitute Resolution 11, A-98)

275.997R Postgraduate Training Requirements for Obtaining Permanent Medical Licensure: That the AMA (1) reaffirm existing policy urging state medical licensing boards to permit graduates of Liaison Committee on Medical Education accredited programs to be licensed for the independent practice of medicine prior to the second year of residency training; and (2) reaffirm opposition to lengthy periods of residency training as part of the requirements for licensure, as tending toward licensure by specialty. (RFS Report J, I-88; Reaffirmed: RFS Report C, I-98)

- 305.991R** Use of Social Security Numbers on Student Loan Accounts: Asked that the AMA work with student loan services and other associated agencies to end the use of Social Security Numbers as account numbers. (RFS Substitute Resolution 1, A-98)
- 310.587R** Data Bank for Poor Outcomes Associated with Excessive Work Hours: Asked (1) that the AMA initiate an anonymous reporting network for adverse outcomes associated with working conditions and the work environment, including excessive work hours and (2) that the AMA-RFS support a national survey of resident work hours and working conditions in order to develop new recommendations regarding work hours and working conditions to optimize resident education and patient care. (RFS Substitute Resolution 5, I-98)
- 310.792R** Collective Negotiations by Residents: Asked 1) that the AMA ask its representatives to the ACGME to continue their diligence in supporting inclusion of the following AMA proposed amended language into Section 1,B,3,e(1) of ACGME's Institutional Requirements:
- Section 1,B,3,e (2) that the AMA approve a nationwide program offering supporting materials and telephone and on-site assistance to groups of residents seeking to form independent housestaff organizations advocating no actions resulting in withholding care; and (3) that the AMA study the potential affects on future resident demand for housestaff associations or unionizations should the NLRB rule that all residents are subject to legal protections under the NLRA and make recommendations as to ways in which the AMA can appropriately address those demands. (RFS Report F, A-98)
- 405.991R** Physician in the Capitol/Statehouse Program: Asked that the AMA-RFS review state programs that encourage specific physicians and congressional interactions, such as "physician for a day" and "key physician contacts" programs, and report the findings to the RFS Assembly. (RFS Substitute Resolution 13, I-98)
- 405.989R** The Disruptive Physician: Asked that the AMA identify and study behavior by physicians that is disruptive to high quality patient care, define the term "disruptive physician" and disseminate guidelines for managing the disruptive physician. (RFS Report H, I-98)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: E
(I-08)

Introduced by: RFS Governing Council

Subject: Final Credentialing for Physicians who Transfer Training Programs and Graduate from the Final Residency Program

Referred to: Reference Committee
(Claudia Reardon, MD, Chair)

1 I. Introduction

2

3 At the 2008 Annual Meeting of the American Medical Association Resident and Fellow Section
4 (AMA-RFS), the Assembly considered Resolution 1, "Final Credentialing for Physicians who
5 Transfer Training Programs and Graduate from the Final Residency Program". The resolution
6 asked:

7

8 That the American Medical Association work with the appropriate accrediting bodies to
9 streamline the credentialing process so that credentialing forms are requested only
10 from the program from which physicians completed their final residency training and
11 from which they graduated with any relevant information from any prior program, i.e.
12 that credentialing forms are requested from the final training program that is in a
13 position to provide a final recommendation about the physicians' qualifications and
14 competencies to practice their chosen specialties.

15

16 The rationale cited for the resolution was that some residents who transferred residency
17 programs had experienced some difficulty or delay in getting credentialed following residency.
18 The Assembly referred the resolution to the RFS Governing Council (GC) for further review.
19 The GC was tasked with researching the resolution and was asked to report back to the RFS
20 Assembly at the I-08 Meeting.

21

22 II. Discussion

23

24 Credentialing is a process that physicians must complete in multiple situations, including initial
25 state licensure, obtaining hospital staff privileges, practicing in an outpatient clinical office
26 setting, practicing at an ambulatory surgery center, being approved by managed care insurance
27 companies, updating clinical privileges, etc.

28

29 This resolution asks the AMA to "work with the appropriate accrediting bodies to streamline the
30 credentialing process," specifically as it pertains to physicians who do a portion of their training
31 at one program and then transfer to another program to complete residency training. Because
32 many credentialing bodies are credentials verification organizations (CVOs) that are "primary
33 source verified," they are required to contact every residency program where a resident was
34 trained. This thorough inquiry into a resident's training is required by the Joint Commission and
35 National Commission on Quality Assurance (NCQA) as part of their accreditation standards and
36 to ensure patient safety.

37

1 The primary purpose for requiring verification from all programs is to ensure that a physician has
2 successfully completed each year of residency training. This includes a complete clinical skills
3 assessment, verification that the resident was in good standing at each program, and
4 confirmation that no disciplinary or punitive actions were taken or are still pending against the
5 resident physician. Several issues can arise when “credentialing forms are only requested from
6 the program from which a physician completed their final residency training.” First, there is no
7 standard procedure that all residency programs use to obtain verification of a resident’s
8 successful completion of a prior residency program; consequently, the verification process of
9 some are more thorough than others. Second, even programs with a thorough verification
10 process can miss critical information. For example, the first training program may be initiating a
11 case review concerning the care provided by a resident. It may then take several months to
12 complete the review, document the problems, initiate a hearing, and take disciplinary action
13 against a resident. Depending on when the resident transfers to a new program, the resident’s
14 file may not contain documentation of any potential problems. These situations can be further
15 exacerbated if the resident has transferred programs several times.

16
17 The resolution also refers to recent changes by some specialty boards to only require
18 verification from the final program which the resident graduated from, as opposed to all
19 programs where the resident was trained, in order to sit for the board qualifying exam. Most
20 boards, however, still require detailed documentation and verification from the residency
21 program director for every year that the resident is in training. The specialty boards are in the
22 best position to determine the depth and frequency that a resident’s credentials must be
23 assessed. Additionally, credentials verifying agencies must meet stringent standards to ensure
24 the information they are reporting is complete, accurate and reliable. Patient safety concerns
25 could be raised if the AMA changed its policy to advocate for less stringent credentialing
26 standards by requesting that only the final residency program be contacted. AMA Policy, which
27 follows below, is quite extensive in this area and addresses the issues raised in this resolution.

28
29
30 **Relevant AMA Policy:**

31
32 **H-180.956 Physician Privileges Application - Timely Review by Managed Care**

33 Our AMA policy is that:(1) final acceptance of residents who otherwise are approved by a health
34 plan should be contingent upon the receipt of a letter from their program director stating that
35 their training has been satisfactorily completed; (2) health plans which require board certification
36 should allow the completing resident to be included in their plan after showing evidence of
37 having completed the required training and of working towards fulfilling the requirements in the
38 time frame established by their respective Board for completion of certification; and (3)
39 Medicare, Medicaid, and managed care organizations should (a) make final physician
40 credentialing determinations within 45 calendar days of receipt of a completed application; (b)
41 grant provisional credentialing pending a final credentialing decision if the credentialing process
42 exceeds 45 calendar days; and (c) retroactively compensate physicians for services rendered
43 from the date of their credentialing. (Res. 708, A-01; Modified Sub. Res. 701, I-01; Reaffirmed:
44 Res. 809, I-02; Reaffirmation A-05)

45
46 **H-275.977 Verifying Physicians' Credentials**

47 The AMA endorses the use of pluralistic approaches to the verification and validation of
48 physicians' credentials. The AMA will seek legislation that managed care companies be
49 required to request credentialing information in a uniform standardized format which all groups
50 involved in credentialing would accept. (Sub. Res. 91, A-87; Amended by Res. 736, A-97;
51 Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)

1 **H-310.929 Principles for Graduate Medical Education**

2 Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these
3 principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies
4 of Graduate Medical Education, if they are not already present. (*Only relevant section included*)
5

6 (6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific
7 GME must operate under a system of institutional governance responsible for the
8 development and implementation of policies regarding the following; the initial
9 authorization of programs, the appointment of program directors, compliance with
10 the Essentials for Accredited Residencies in Graduate Medical Education, the
11 advancement of resident physicians, the disciplining of resident physicians when
12 this is appropriate, the maintenance of permanent records, and the credentialing
13 of resident physicians who successfully complete the program. If an institution
14 closes or has to reduce the size of a residency program, the institution must
15 inform the residents as soon as possible. Institutions must make every effort to
16 allow residents already in the program to complete their education in the affected
17 program. When this is not possible, institutions must assist residents to enroll in
18 another program in which they can continue their education. Programs must also
19 make arrangements, when necessary, for the disposition of program files so that
20 future confirmation of the completion of residency education is possible.
21 Institutions should allow residents to form housestaff organizations, or similar
22 organizations, to address patient care and resident work environment concerns.
23 Institutional committees should include resident members.
24

25 **H-310.921 Credentialing Materials: Timely Submission by Residency and Fellowship**
26 **Programs**

- 27 1. Our AMA encourages residency programs and fellowship programs to submit credentialing
28 and verification data requested on behalf of their graduating residents and fellows to the
29 requesting agency within thirty days of the request.
30 2. Our AMA encourages the Accreditation Council for Graduate Medical Education to establish
31 an accreditation standard for residency and fellowship programs calling for submission of
32 credentialing and recredentialing verification data requested on behalf of their graduating
33 residents and fellows to the requesting agency within thirty days of the request. (Res. 312, A-07)
34

35 **D-180.993 Prompt Initial Credentialing of Physicians by Managed Care Plans**

36 Our AMA will: (1) continue to work with relevant entities, such as the National Committee for
37 Quality Assurance (NCQA), the American Accreditation HealthCare Commission/URAC, and
38 the Centers for Medicare and Medicaid Services (CMS), to adopt AMA policies related to the
39 timely credentialing of physicians; (2) develop model state legislation to effect AMA policy on the
40 timely credentialing of physicians; and (3) urge state medical associations to advocate the
41 introduction and enactment of AMA model state legislation on timely credentialing by their state
42 legislatures. (Sub. Res. 701, I-01)
43

44 **D-275.994 Facilitating Credentialing for State Licensure**

45 Our AMA will: (1) encourage the Federation of State Medical Boards to urge its Portability
46 Committee to complete its work on developing mechanisms for greater reciprocity between
47 state licensing jurisdictions as soon as possible; (2) work with the Federation of State Medical
48 Boards and the Association of State Medical Board Executive Directors to encourage the
49 increased standardization of credentials requirements for licensure, and to increase the number
50 of reciprocal relationships among all licensing jurisdictions; and (3) encourage the Federation of
51 State Medical Boards and its licensing jurisdictions to widely disseminate information about the

1 Federation's Credentials Verification Service, especially when physicians apply for a new
2 medical license. (Res. 302, A-01)

3
4 **D-275.995 Licensure and Credentialing Issues**

5 Our AMA will: (1) support recognition of the Federation of State Medical Boards' (FSMB)
6 Credentials Verification Service by all licensing jurisdictions;

7 (2) work jointly with the FSMB to take measures to encourage increased standardization of
8 credentials requirements, and improved portability by increased use of reciprocal relationships
9 among all licensing jurisdictions;

10 (3) communicate, either directly by letter or through its publications, to all hospitals and
11 licensure boards that the Joint Commission on Accreditation of Healthcare Organizations
12 encourages recognition of both the Educational Commission for Foreign Medical Graduates'
13 Certification Verification Service and the AMA's Masterfile as primary source verification of
14 medical school credential; and

15 (4) encourage the National Commission on Quality Assurance (NCQA) and all other
16 organizations to accept the Federation of State Medical Boards' Credentials Verification
17 Service, the Educational Commission for Foreign Medical Graduates' Certification Verification
18 Service, and the AMA Masterfile as primary source verification of credentials. (Res. 303, I-00;
19 Reaffirmation A-04)

20
21 **III. Conclusion**

22
23 One of the main objectives of the credentialing process is to verify all aspects of a resident's
24 training, which encompasses the entire residency period, not just the final year(s) of residency
25 that lead to graduation from a particular program. An AMA action requesting that credentialing
26 agencies only verify the final years of training at a specific program could be perceived as
27 requesting the use of a lower credentialing standard that could jeopardize patient safety.
28 Currently, the AMA has policy stating that there should be no undue delay or unwillingness by
29 any residency program to submit proper, timely documentation to any credentialing agency,
30 hospital, state licensing board, or physician who requests it. Specifically, AMA policy details the
31 expectation that residency programs have an outlined process for resident credentialing and
32 should ensure timely release of that information when requested (within 30 days). Additionally,
33 current policy requests that the AMA "work jointly with the FSMB to take measures to encourage
34 increased standardization of credentials requirements, and improved portability by increased
35 use of reciprocal relationships among all licensing jurisdictions." Further, AMA policy
36 encourages "the National Commission on Quality Assurance (NCQA) and all other
37 organizations to accept the Federation of State Medical Boards' Credentials Verification
38 Service, the Educational Commission for Foreign Medical Graduates' Certification Verification
39 Service, and the AMA Masterfile as primary source verification of credentials."
40

41 **IV. Recommendations**

42
43 The Governing Council recommends:

- 44
45 1. Reaffirmation of current AMA policy in lieu of adopting Resolution 1: Final Credentialing
46 for Physicians who Transfer Training Programs and Graduate from the Final Residency
47 Program (AMA-RFS, A-08)
48

Fiscal Note: None

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report:F
(I-08)

Introduced by: RFS Governing Council

Subject: Expanding Underrepresented Minority Voices in the AMA-RFS

Referred to: Reference Committee
(Claudia Reardon, MD, Chair)

I. Introduction

Currently there are no official mechanisms for national minority physician organizations to be officially involved in the American Medical Association Resident and Fellow Section (AMA-RFS) Assembly. To address this issue, Resolution 9 entitled "Expanding Minority Voices in the AMA Resident and Fellow Section" was presented at the RFS annual meeting in June, 2008. The resolution asked for the RFS to revise its bylaws "to allow seating of a delegate to the AMA Resident and Fellow Section Assembly for one representative from each national (underrepresented) minority medical organization, including but not limited to the National Medical Association (NMA), the National Hispanic Medical Association (NHMA), and the Association of American Indian Physicians." This resolution was referred to the AMA-RFS Governing Council. The RFS standing committee on membership recruitment and retention was asked to examine and evaluate the possibility of expanding membership and increasing involvement of underrepresented minority physician organizations in the RFS Assembly.

II. Background

The problem of underrepresented racial and ethnic minorities in medicine continues to persist: African Americans, Hispanics, and Native Americans together make up over 25% of the U.S. population; however, only 6.4% of practicing doctors come from these groups, according to the American Association of Medical Colleges¹. While the AMA recently amended its bylaws to establish a seat in its House of Delegates (AMA-HOD) for a representative of the Minority Affairs Consortium to help enhance the voice of minority physicians in the house of medicine, the RFS does not have any seats in its assembly set aside for minority representatives.

National medical organization representation in AMA-HOD

In order to be recognized and represented in the HOD, an organization must first be a member of the AMA Specialty and Service Society (SSS). The SSS is the largest caucus in the HOD, and is made up of over 130 national medical societies, military service groups and professional interest medical associations (PIMAs). The SSS meets twice annually in conjunction with the Interim and Annual HOD Meetings. There are two categories of groups in the SSS. First, there are those societies that have seats in the HOD and then there are those who have representation through the SSS but are seeking admission (a delegate seat) in the HOD. An association must first be represented in the SSS for three years before they are eligible to seek admission to the HOD and these groups are typically referred to as "SSS groups." At any given time there are approximately 20 or more SSS groups waiting to gain admission to the HOD. In addition to participation in the SSS, societies must also comply with several other criteria for admission to the HOD including presenting a resolution from their national assembly meeting

1 asking for representation in the HOD, and the organization must have at least 50% of its
2 members also enrolled as AMA members.

3
4 Out of the three national minority physician organizations comprised of underrepresented
5 minorities, only the National Medical Association (representing African-American physicians)
6 currently has a seat in the HOD. The National Hispanic Medical Association and the
7 Association of American Indian Physicians do not currently have a seat in the HOD or
8 representation through SSS. The Korean American Medical Association and the American
9 Association of Physicians of Indian Origin are the other two ethnic/minority physician
10 organizations that have a seat in the HOD. Additionally, two ethnic medical associations, the
11 National Arab-American Medical Association and the Association of Pakistani Physicians of
12 North America are currently "SSS Groups," waiting to gain admission to the HOD.

13
14 *National medical organization representation in AMA-MSS*

15 There are currently two routes through which medical student organizations acquire
16 representation in the AMA-MSS Assembly. First, AMA Bylaw 7.333 provides for representation
17 in the MSS Assembly for the established student component of any organization represented in
18 the AMA House of Delegates. Student organizations that have acquired representation through
19 this route include, for example, the student section of the American College of Emergency
20 Physicians (student component of a national medical specialty society) and Student National
21 Medical Association (student component of NMA, a professional interest medical association).

22
23 The second route, through AMA Bylaw 7.334, provides for representation in the MSS Assembly
24 of National Medical Student Organizations (NMSO) that meet the criteria outlined in AMA Bylaw
25 7.3341: (a) The organization must be national in scope; (b) A majority of the voting members of
26 the organization must be medical students enrolled in educational programs as defined in Bylaw
27 1.11 (LCME- or AOA-accredited programs); (c) Membership in the organization must be
28 available to all medical students, without discrimination; (d) The purposes and objectives of the
29 organization must be consistent with the AMA's purposes and objectives; and (e) The
30 organization's code of medical ethics must be consistent with the AMA's Principles of Medical
31 Ethics. Student organizations that have acquired representation through the NMSO route
32 include the Asian Pacific American Medical Student Association, the Military Medical Student
33 Association, and the National Network of Latin American Medical Students. Organizations
34 pursuing representation in MSS as NMSOs are generally *true* student organizations in that they
35 are not officially affiliated with parent organizations.

36
37 III. Discussion

38
39 Although major minority medical organizations such as NMA and AAIP have official medical
40 student sections as part of the parent organization, they do not have official resident and fellow
41 sections. While each of these organizations are certainly national in scope and their goals of
42 increased patient and physician advocacy are in line with the principles and goals of the AMA, it
43 is the extent to which their members are also AMA members, and whether the leadership of
44 these organizations desire involvement in the AMA (in the HOD and/or in the RFS), that must be
45 determined.

46
47 While the AMA has been making significant efforts to increase minority involvement in the AMA
48 as a whole, there appear to be significant obstacles toward increasing physician minority group
49 involvement in the RFS Assembly. While the MSS has clear bylaws regarding how
50 organizations with distinct medical student sections are able to join the MSS without the parent
51 organization becoming a member of the HOD, the RFS has no such bylaws. Currently, the
52 mechanisms for physician organizations to join the HOD is quite complex, requiring involvement

1 in the SSS for at least three years before an organization can even be considered for
 2 membership in the HOD. Clearly, it would be difficult to increase minority group representation
 3 in the RFS assembly now, if the organizations were first required to have the parent minority
 4 physician groups join the HOD through the three-year SSS process. Ideally, the RFS should be
 5 able to admit groups into the RFS Assembly without requiring the parent minority physician
 6 organizations to join the HOD.

7 8 IV. Conclusion

9
10 It is unclear what the best method to include minority representative organizations in the RFS
 11 Assembly. It will be difficult for the RFS to include minority organizations in a manner similar to
 12 the MSS, both because the major minority physician organizations do not have resident and
 13 fellow sections to date, and because there are not currently clear bylaws outlining how a
 14 member organization can join the RFS without first being a member of the HOD. Therefore,
 15 before the RFS can increase minority representation in the RFS, it must first develop a clear,
 16 systematic mechanism of inviting organizations to become members of our section and then
 17 research each of the minority physician organizations to ensure that they have sufficient
 18 resident and fellow infrastructure and AMA membership to be suitable partners with the RFS.

19 20 V. Recommendations

21
22 The Governing Council recommends:

- 23 1. That the AMA-RFS create bylaws to specifically and systematically outline how a
24 minority physician organization may gain representation in the RFS national assembly;
- 25 2. That the AMA-RFS research the major underrepresented minority physician
26 organizations with a focus on the level of involvement of resident and fellow members in
27 each organization, on the percentage of AMA members in each organization, and on the
28 level to which each minority physician organization desires to be involved with the AMA-
29 RFS;
- 30 3. That the AMA-RFS leadership work with the Specialty and Service Society (SSS) to
31 determine the needed steps that minority physician organizations would have to take to
32 become seated members of the AMA-HOD;
- 33 4. That the AMA-RFS report back to the RFS assembly on this issue at A-09.

Fiscal Note: TBD

Relevant AMA Bylaws

B-7.333 National Medical Specialty Societies, Federal Services, and Professional Interest Medical Associations.

Each national medical specialty society, Federal Service, and professional interest medical association granted representation in the House of Delegates that has established a medical student component is entitled to one representative and one alternate representative selected by the medical student members of the organization. The Governing Council shall adopt uniform rules and criteria to determine if an organization represented in the House of Delegates has established a medical student membership component so as to qualify for representation at the Business Meeting. The procedure by which the medical student representative from the organization is selected must meet the requirements established by the Governing Council.

B-7.334 National Medical Student Organizations.

National medical student organizations that have been granted representation in the Medical Student Section Business Meeting may select one representative and one alternate representative.

B-7.3341 Criteria for Eligibility.

National medical student organizations that meet the following criteria may be considered for representation in the Medical Student Section Business Meeting:

- a. The organization must be national in scope.
- b. A majority of the voting members of the organization must be medical students enrolled in educational programs as defined in Bylaw 1.11.
- c. Membership in the organization must be available to all medical students, without discrimination.
- d. The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives.
- e. The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.

References

1. AAMC Data Warehouse, Minority Physician Database, Applicant-Matriculant File, and AMA Physician Masterfile, as of March 16, 2006. www.aspiringdocs.com

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: G
(I-08)

Introduced by: AMA-RFS Committee on Long Range Planning

Subject: Bylaws Changes for AMA-RFS Sectional Delegates and Alternate Delegates
Election Procedures and Vacancies

Referred to: Reference Committee
(Claudia Reardon, MD, Chair)

1 I. INTRODUCTION

2
3 At the 2008 Annual Meeting, the Resident and Fellow Section (RFS) Assembly passed
4 Governing Council Report H, "Voting Systems for Election of RFS Sectional Delegates and
5 Alternate Delegates," which changed the voting mechanism from Instant Run-Off Elections to
6 Simple Majority. The Governing Council and the RFS Committee on Long Range Planning
7 were asked to determine appropriate language for the RFS Internal Operating Procedures (IOP)
8 to reflect this change. Additionally, in the light of recent vacancies in the Sectional
9 Delegate/Alternate Delegate position, the Governing Council and the Committee on Long Range
10 Planning drafted IOP language that would reflect how these situations should be dealt with.

11
12 II. BACKGROUND

13
14 I. *Voting System for Sectional Delegates & Alternate Delegates*

15
16 The initial RFS voting system for the Election of Sectional Delegates and Alternate Delegates to
17 the AMA-House of Delegates (HOD) was Instant Runoff. At the 2008 Annual meeting, the RFS
18 Assembly determined that a voting system which used Plurality was most desirable for the
19 election of Sectional Delegates and Alternate Delegates. Using this system a voter does not rank
20 candidates but instead selects the top number n of candidates as winners for n positions available.
21 Despite adopting this change, there was no consensus at the time of the meeting on the IOP
22 changes needed to implement the new system for the 2008 Interim meeting. It was requested
23 that proposed IOP changes be made at the 2008 Interim meeting, which could be then be
24 implemented at the next meeting in which an election of Section Delegates or Alternate Delegate
25 would take place.

26
27 II. *Internal Operating Procedure Changes Needed*

28
29 In the following excerpt from the IOPs, shaded sections highlight text that would require
30 modification to reflect the change from Instant Runoff to Plurality voting.

31
32 **RFS Internal Operating Procedures section IV. RFS Sectional Delegates, G. Election of Sectional**
33 **Delegates, i. Balloting**

34 i. Balloting. All nominees for the office of Sectional Delegate shall be listed on a single ballot. A separate
35 ballot will be provided to each elector, listing each nominee's name and endorsing society. Each elector

1 will rank-order the nominees numerically, with the rank of "1" being the highest rank. Electors must rank
2 order all nominees otherwise the ballot is voided. Also, duplicating a rank (i.e. ranking two candidates with
3 the same number), and/or skipping a rank (e.g. ranking 5 candidates 1, 2, 4, 5, 6) will void the ballot. When
4 counting the ballots, the voided ballots shall be placed in a separate stack and shall not be considered in the
5 total required to elect. A majority of the legal ballots cast shall be required for election. Each legal ballot
6 shall be examined for the nominee with the highest rank and sorted accordingly. After sorting, ballots
7 assigned to each nominee shall be counted, any nominee receiving a majority of the legal ballots cast shall
8 be elected. If in any round, no nominee receives a majority, the nominee(s) with the fewest votes shall be
9 eliminated. In either circumstance, ballots are then redistributed to the highest designated of the remaining
10 nominees and then recounted. This process will continue until all Sectional Delegate seats are filled.

11 ii. Limitations. If there is more than one nominee from an endorsing society, then the nominee from that
12 endorsing society who has a majority and who has the most votes shall be elected. All other nominees from
13 that society shall be eliminated from the remaining counting of ballots. This process will continue
14 throughout the counting of ballots to ensure that there is only one RFS Sectional Delegate per endorsing
15 state and specialty society.

16 iii. Unfilled Seats. If after the counting process, and due to limitations of representation and/or failure of
17 remaining eligible nominees to gain a majority vote, there are unfilled Sectional Delegate seats, the
18 following processes will be used to fill those seats. When using these legal ballots to decide unfilled seats,
19 original ranking will be used.

20 a) First, all nominees eliminated from consideration in the above section (ii. Limitations) due to
21 limitations on representation of endorsing societies, and who still has a majority of legal votes may be
22 elected under a secondary state and/or specialty society endorsement if that particular state or specialty
23 society has not already been represented.

24 b) If unfilled seats still remain, then the counting process will recommence using the original rank
25 order votes to establish majorities within that remaining group. Again, limitations will be placed only
26 allowing one extra Sectional Delegate per endorsing state and specialty society. This process will
27 continue through as many counting rounds as needed until all Sectional Delegate seats are filled. With
28 each subsequent counting round the limitation of Sectional Delegates shall increase by one.
29
30

31 *III. Vacancies of Sectional Delegate and Alternate Delegate Positions*

32

33 Since the election of our 2008 RFS Sectional Delegates and Alternate Delegates at the 2007
34 Interim meeting, there have been two separate circumstances in which the promotion of a
35 Sectional Delegate/Alternate Delegate left a vacancy. The first situation occurred when the
36 promotion of a Sectional position occurred during the Annual meeting, though the vacant
37 position would not need to be fulfilled until the following meeting. With this vacancy,
38 immediate elections for the vacant position were held, and the winner obtained society
39 endorsement after the meeting. The second vacancy occurred between the Annual and Interim
40 meetings, and the vacant position needed to be filled at the Interim meeting. Because of the late
41 nature of this vacancy and the IOP requirement of holding elections for the vacant position, the
42 election for this position are to be held at the same meeting as the fulfillment of the sectional
43 position term. Having elections at the same meeting as the fulfillment of the term is difficult for
44 multiple reasons, not limited to requiring a member to take time away from their program and
45 find housing during the meeting without winning the position ahead of time, obtaining endorsing
46 sponsorship for that meeting despite a potential election loss, and the amount of preparation the
47 potential electee may need to do for the HOD even if he or she is not elected to the position.
48 Because of these situations and the hardships caused by replacing a vacant Sectional position at
49 the same meeting as the term is to be fulfilled, our Committee determined that further
50 clarification and adjustment to the IOP is needed.

1
2 It was determined that when elections could be held in advance of a vacancy (i.e. when the
3 person leaving the vacancy can fulfill their position at the meeting during which the elections are
4 taking place), the IOP should be unchanged; an election using Plurality vote should be used, and
5 the position filled based on majority vote. In the situation in which elections cannot be held at a
6 full meeting in advance of the Sectional position fulfillment, it might be in the best interest of the
7 person filling the vacancy to be aware of the work-load, and requirement to stay for the entire
8 length of the AMA-HOD ahead of time. Because of this, we would recommend that the
9 Governing Council appoint an AMA-RFS member who would be willing to fill the vacancy, and
10 who would meet the requirements of the Sectional position.
11

12 13 III. RECOMMENDATIONS

14 The RFS Committee on Long Range Planning recommends that the following be adopted and
15 that the remainder of the report be filed:

- 16 1. That the AMA-RFS IOP be changed (by deletion and insertion) in Section VI.G.5.a. as
17 following to reflect the Plurality voting system adopted at the 2008 Annual meeting:

18 i. Balloting. All nominees for the office of Sectional Delegate shall be listed on a single
19 ballot with their endorsing society. The ballot will contain clear voting instructions with
20 a brief explanation of ballot counting procedures. The voter may select up to and
21 including the number of candidate positions. Ballots will be counted and delegates
22 selected based on an approval-based, plurality-at-large voting system. Only nominees
23 receiving a simple majority of the legal votes cast shall be elected. A separate ballot will
24 be provided to each elector, listing each nominee's name and endorsing society. Each
25 elector will rank order the nominees numerically, with the rank of "1" being the highest
26 rank. Electors must rank order all nominees otherwise the ballot is voided. Also,
27 duplicating a rank (i.e. ranking two candidates with the same number), and/or skipping a
28 rank (e.g. ranking 5 candidates 1, 2, 4, 5, 6) will void the ballot. When counting the
29 ballots, the voided ballots shall be placed in a separate stack and shall not be considered
30 in the total required to elect. A majority of the legal ballots cast shall be required for
31 election. Each legal ballot shall be examined for the nominee with the highest rank and
32 sorted accordingly. After sorting, ballots assigned to each nominee shall be counted, any
33 nominee receiving a majority of the legal ballots cast shall be elected. If in any round, no
34 nominee receives a majority, the nominee(s) with the fewest votes shall be eliminated. In
35 either circumstance, ballots are then redistributed to the highest designated of the
36 remaining nominees and then recounted. This process will continue until all Sectional
37 Delegate seats are filled.

38
39 ii. Limitations. If there is more than one nominee from an endorsing state or specialty
40 society, then only the nominee from that endorsing society who has a majority and who
41 has the most votes shall be elected. All other nominees from that society shall be
42 eliminated from the remaining counting of ballots. This process will continue throughout
43 the counting of ballots to ensure that there is only one RFS Sectional Delegate per
44 endorsing state and specialty society.

45
46 iii. Unfilled Seats. If there are unfilled Sectional Delegate seats after the election, the

1 ballot counting process will begin again, allowing only one additional Sectional Delegate
 2 per endorsing state/specialty society. This process will continue through as many
 3 counting rounds as needed until all Sectional Delegate seats are filled. With each
 4 subsequent counting round, the limitation of Sectional Delegate from a given state or
 5 specialty society shall increase by one. If after the counting process, and due to
 6 limitations of representation and/or failure of remaining eligible nominees to gain a
 7 majority vote, there are unfilled Sectional Delegate seats, the following processes will be
 8 used to fill those seats. When using these legal ballots to decide unfilled seats, original
 9 ranking will be used.

10
 11 a) ~~First, all nominees eliminated from consideration in the above section (ii.~~
 12 ~~Limitations) due to limitations on representation of endorsing societies, and who~~
 13 ~~still has a majority of legal votes may be elected under a secondary state and/or~~
 14 ~~specialty society endorsement if that particular state or specialty society has not~~
 15 ~~already been represented.~~

16
 17 b) ~~If unfilled seats still remain, then the counting process will recommence~~
 18 ~~using the original rank order votes to establish majorities within that remaining~~
 19 ~~group. Again, limitations will be placed only allowing one extra Sectional~~
 20 ~~Delegate per endorsing state and specialty society. This process will continue~~
 21 ~~through as many counting rounds as needed until all Sectional Delegate seats are~~
 22 ~~filled. With each subsequent counting round the limitation of Sectional Delegates~~
 23 ~~shall increase by one.~~

24
 25 iv. Run-Off Elections. If there are two or more candidates that tie for the highest number of
 26 votes, though there are fewer positions available than tied candidates, a Run-Off election will
 27 occur. The candidates who tied will be placed on a subsequent ballot with all other
 28 candidates removed, and a subsequent vote shall take place. The candidate(s) who receive(s)
 29 the highest number of votes, with a majority of legal votes cast, shall be elected. If in any
 30 round, no nominee receives a majority, the nominee(s) with the fewest votes shall be
 31 eliminated. This process will continue until all Sectional Delegate and Alternate Delegate
 32 seats are filled.

- 33
 34 2. That the AMA-RFS IOP be changed (by deletion and insertion) in Section VI as following to
 35 reflect the issues related to vacancies in the Sectional Delegate/Alternate Delegate position:

36 **I. Vacancies.**

37
 38 1. Vacancy to be filled at the next meeting. In the case that a vacancy in the position of
 39 Sectional Delegate or Alternate Delegate occurs one meeting prior to which the term is to be
 40 fulfilled, the Governing Council shall inform the assembly of the number of vacancies and an
 41 election according to the procedures defined in RFS Internal Operating Procedures VI.G shall
 42 occur at the following meeting of the RFS Assembly.

43 ~~Between meetings of the House of Delegates. In the case of a vacancy in the position of~~
 44 ~~Sectional Delegate or alternate delegate in-between meetings, the governing council shall inform~~
 45 ~~the assembly of the number of vacancies and an election according to the procedures defined in~~
 46 ~~RFS Internal Operating Procedures VI.G shall occur at the following meeting of the RFS~~
 47 ~~Assembly.~~

1
2 2. Other Vacancies. Should a vacancy arise in the position of Sectional Delegate for which an
3 election will not take place prior to the start of the meeting during which any portion of the term
4 is to be fulfilled after the close of elections in the RFS assembly and prior to close of business of
5 the House of Delegates, elected alternate delegates shall assume the role of delegates. Should
6 there still remain Delegate vacancies, these, along with the alternate delegate vacancies shall be
7 filled by a nomination and majority vote of the members of the RFS Governing Council who are
8 present. These Delegates and Alternate Delegates shall not be subject to the requirement of state
9 or specialty society endorsement.

10

11

12 Acknowledgements:

13 RFS CLRP Members

14

15 Special thanks to AMA-RFS Staff:

16 Sharyn Grose

17 Anu Gupta

18

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Late Report: G
(I-08)

Introduced by: AMA-RFS Legislative Advocacy Committee
Subject: President Barack Obama's Health Care Plan
Referred to: Reference Committee
(Claudia Reardon, MD, Chair)

I. Introduction

During the 2008 campaign, President-Elect Barack Obama introduced a set of proposals to reform the US health care system, and will likely propose legislation in 2009 to implement some of these proposals. Also during the 2008 campaign, the AMA has sponsored the Voice for the Uninsured campaign, and has publicized the AMA Plan for Reform. In order that our membership be informed and prepared for this legislative year, your Legislative Advocacy Committee reviewed the AMA Plan and President Obama's plan, and presents this report outlining similarities and differences between the two, along with recommendations on possible new directions in AMA policy in response to these proposals in selected areas of importance. Any legislative solution is sure to be a compromise of pieces offered by Congress and the Executive branch, on a bipartisan basis, and this report is intended as a first step in these negotiations on the part of the AMA, with much more exciting discussion to come. This report is intended to help to focus our policy in this upcoming debate, and to give our leadership guidance in those ongoing conversations.

II. Discussion

Overall approach to expanding access to coverage

The proposed plan: President Obama's health care proposal would require that: 1) all children have health insurance 2) access to health insurance for adults be expanded by expanding Medicaid and SCHIP as well as creating a new public plan 3) all employers offer "meaningful" coverage or contribute a percentage of their payroll toward the costs of the new public plan (with small businesses exempt)^{1,2}. 4) A new National Health Insurance Exchange be created to allow small businesses and individuals without access to other public programs or employer-based coverage to enroll in the new public plan or in approved private plans.

Issues to consider and existing AMA policy: The proposed health care plan does not include universal health insurance coverage, while our AMA's Cover the Uninsured campaign advocates for universal coverage for all U.S. citizens.³ Many U.S. citizens are unemployed or not employed by businesses that offer health insurance, and thus would not be required to have health insurance under the proposed health care plan.

Next steps: Our AMA should support the proposal to require all children to have health insurance as a strategic priority, but in accordance with our policy, should advocate for expansion of the proposed health care plan to include health insurance coverage for all U.S. citizens.

1 Expansion of public programs

2 *The proposed plan:* President Obama calls for expansion of public programs to include
3 expansion of Medicaid and SCHIP as well as the creation of a new public plan to capture those
4 unable to find insurance elsewhere.^{1,2}

5
6 *Issues to consider and existing AMA Policy:* There is an ongoing tension within organized
7 medicine towards publicly-funded programs, as a very large public program has the potential to
8 operate monopolistically offering reimbursements that do not reflect the actual cost of care.
9 Ultimately under this scenario the patients suffer as providers cannot afford to provide care to
10 these publicly insured patients.

11
12 *Next steps:* Going forward care must be taken to ensure that this new public plan is kept in
13 check, to ensure that its reimbursements reflect the actual costs of care, allowing physicians to
14 treat any citizen who enters their care. If we are to expand public programs, we should begin
15 with our children and younger population. Some recent developments in this area include the
16 possibility to expand SCHIP and to allow children to remain on their parent's insurance until the
17 age of 25, something we as a committee believe that the AMA should support.

18
19
20 Subsidies to Individuals and Employers:

21 *The proposed plan:* The proposed plan would make federal income-related subsidies (in an
22 unspecified amount) available to help individuals buy this proposed new public plan or other
23 qualified insurance and would provide small businesses with a refundable tax credit of up to 50
24 percent of premiums paid on behalf of their employees if the employer pays a "meaningful
25 share" of the cost of "a quality health plan".^{1,2} This plan, coupled with individual choice, tax
26 credits or subsidies benefit recipients directly, and everyone indirectly, by stimulating the market
27 for health insurance. In theory, if enough people have enough purchasing power, and enough
28 say over how that purchasing power is used, insurers will be compelled to offer better, more
29 affordable coverage options.³

30
31 *Issues to Consider and Existing AMA Policy:* The AMA's Plan and Cover the Uninsured
32 campaign holds individual choice as one of its central tenets. The proposed provision of tax
33 credits to citizens for selection and purchase of health insurance supports that choice.³ The
34 intent is that with increasing individual choice and market pressures, premiums for individuals
35 would fall. However, In 2007 the average annual cost of health insurance premiums to a family
36 of four was approximately \$12,000¹². If individual choice is to be achieved, it is imperative that
37 these tax credits are substantial enough to allow the un-insured to purchase healthcare.

38
39 *Next Steps:* Going forward the AMA will need to work closely with lawmakers to ensure that
40 these tax credits will be of sufficient value as to allow the purchase of insurance with minimal
41 personal subsidy.

42
43
44 Creation of insurance pooling mechanisms

45 *The proposed plan:* The proposal for insurance pooling mechanisms includes creation of a
46 National Health Insurance Exchange through which individuals could purchase the proposed
47 new public plan or qualified private insurance plan. Under the National Health Insurance
48 Exchange, insurers would be required to: offer coverage on a guaranteed issue basis; charge a
49 fair and stable premium that is not rated on the basis of health status; and meet standards for
50 quality and efficiency.^{1,2}

51 Additionally, this proposed National Health Insurance Exchange reportedly would require
52 participating insurance companies to offer comprehensive benefits similar to those available

1 through Federal Employees Health Benefits Program (FEHBP), but the details of required
2 benefits and degree of similarity to FEHBP are not described.^{1,2} The proposed National Health
3 Insurance Exchange would evaluate participating plans and make differences among them
4 transparent.^{1,2}

5
6 *Issues to consider and existing AMA policy:* one of the central tenets of our AMA's Cover the
7 Uninsured campaign is individual and family choice in what health plan to join, and informed
8 choice can only be made when the details of health insurance plans are made available and
9 understandable to consumers.³

10
11 *Next steps:* It will be important going forward for our AMA to work with the federal government in
12 helping to develop the details of the proposed National Health Insurance Exchange in order to
13 ensure that participating insurance plans provide high quality of and access to health care as
14 well as ensure that physician reimbursement through the National Health Insurance Exchange
15 reflects actual cost of care. It is clear that making differences in coverage provided by health
16 insurance plans transparent will be critical to creating an informed consumer.

17
18
19 Changes to private insurance

20 *The proposed plan:* The proposed changes to private insurance include: prohibiting insurers
21 from denying coverage based on pre-existing conditions; requiring that children up to age 25
22 continue family coverage through their parents' plan; requiring that in market areas where little
23 competition exists that insurers pay out a "reasonable share" of premiums on patient care
24 benefits, thereby preventing insurers from abusing monopoly power through unjustified price
25 increases; and, requiring health plans to disclose the percentage of their premiums that actually
26 go toward paying for patient care as opposed to administrative costs.^{1,2}

27
28 *Issues to consider and existing AMA policy:*

29 It is extremely difficult for many citizens with pre-existing conditions to obtain health insurance.⁴

30
31 Young adults ages 18-25 represent one of the largest groups of uninsured U.S. citizens.⁵

32
33 The insurance business today is dominated by a small group of large companies that have
34 taken over smaller companies, with over 400 health care mergers in the last 10 years, and just
35 two companies dominating a third of the national market.⁶ The American Medical Association
36 has reported that 95% of insurance markets in the United States are highly concentrated⁶, with
37 the result that several geographic areas have insufficient levels of competition among health
38 insurance companies. These changes were supposed to make the industry more efficient, but
39 instead premiums have markedly increased by over 87 percent over the past six years.⁷ Over
40 the same time period, insurance administrative overhead has been the fastest-growing
41 component of health spending. The 2007 Commonwealth Fund Commission on a High
42 Performance Health System reported that between 2000 and 2005, administrative overhead,
43 including both administrative expenses and insurance industry profits, increased 12.0 percent
44 per year, 3.4 percentage points faster than the average health expenditure growth of 8.6
45 percent.⁸ Insufficient competition among health insurance companies can thus lead to significant
46 price increases via abuse of monopoly power. If insurance companies are forced to pay out a
47 "reasonable share" of premiums on patient care benefits, there could be less incentive for them
48 to unjustifiably raise their premiums.

49
50 *Next steps:* First, our AMA should support the proposed prohibition against private insurers
51 denying insurance coverage on the basis of pre-existing conditions. Second, our AMA should
52 also support the proposed requirement for private insurers that children up to age 25 continue

1 family coverage through their parents' plan. Third, our AMA should support the proposed
2 requirement for private insurers that in market areas where there is not enough competition that
3 insurers pay out a "reasonable share" of premiums on patient care benefits, thereby preventing
4 insurers from abusing monopoly power through unjustified price increases. And lastly, our AMA
5 should support increased transparency of insurance premium costs that actually go toward
6 paying for patient care as opposed to administrative costs.

9 Cost containment

10 *The proposed plan:* The proposed cost containment strategies include: investment of \$50
11 billion toward adoption of electronic medical records and other health information technology;
12 promotion of insurer competition through the National Health Insurance Exchange and by
13 regulation of the portion of health plan premiums that must be paid out in benefits; improvement
14 in prevention and management of chronic conditions; initiation of policies to promote generic
15 drugs, allow drug reimportation, and repeal the ban on direct price negotiation between
16 Medicare and drug companies; requirement of hospitals and providers to publicly report
17 measures of health care costs and quality; and reformation of medical malpractice while
18 preserving patient rights by strengthening antitrust laws and promoting new models for
19 addressing physician errors.^{1,2}

20
21 *Issues to consider and existing AMA policy:* Most medical records are still stored on paper,
22 which can make them difficult to use to coordinate care, measure quality, or reduce medical
23 errors. Processing paper claims costs twice as much as processing electronic claims. A study
24 by the Rand Corporation found that if most hospitals and physicians' offices adopted electronic
25 health records, up to \$77 billion of savings would be realized each year through improvements
26 such as reduced hospital stays, avoidance of duplicative and unnecessary testing, more
27 appropriate drug utilization, and other efficiencies.⁹ However, mandated use of electronic
28 medical records could place much of the financial burden of implementation of such systems on
29 individual physicians and health care facilities, while financially benefiting insurance companies.

30
31 Regarding cost containment by improvement in prevention of chronic conditions, many leaders
32 propose such an ideal but do not concomitantly promote funding changes to make this feasible.

33
34 Many of these proposals for cost containment relate to control of drug costs. Some drug
35 manufacturers are explicitly paying generic drug makers not to enter the market so they can
36 preserve their monopolies and keep charging Americans high prices for brand name products.¹⁰
37 In the proposed plan, large drug companies would be prohibited from keeping generics out of
38 markets. Also, the proposal calls for increased use of generic drugs in the new public plan,
39 Medicare, Medicaid, and FEHBP. However, not all prescription drugs have generic equivalents.
40 Thus, implementation of such mandates to use primarily generic medications could save
41 money, but also could compromise patient care.

42
43 Finally, there is concern that mandates such as those proposed for hospitals and providers to
44 publicly report measures of health care costs and quality could very well place undue time and
45 financial demands on health care providers. The details of quality measures to be reported are
46 not yet described.

47
48 *Next steps:* Our AMA should support the proposed cost containment strategy of investment of
49 federal funds toward adoption of electronic medical records and other health information
50 technology, but not support any concomitant mandated use of electronic medical records that is
51 insufficiently funded. Additionally, our AMA should work with the federal government in further
52 expanding the proposal to improve prevention of chronic conditions by advocating for improved

1 reimbursement for preventive health interventions and training. We would also caution that if
2 the new public plan, Medicare, Medicaid, and FEHBP work to develop significant limits on use
3 of brand name medications, that our AMA work closely with these plans to ensure that access to
4 medications without equivalent generics is not limited. Finally, our AMA should work with the
5 federal government to ensure that the proposal to require hospitals and providers to publicly
6 report measures of health care costs and quality does not place undue time and financial
7 demands on health care providers and is based on well-validated and established health care
8 quality indicators that have been developed with the input of physicians.

9
10
11 Improving quality/health system performance

12
13 *The proposed plan:* Proposals for improving quality/health system performance include:
14 rewarding provider performance through the National Health Insurance Exchange and other
15 public programs; promoting preventive care and chronic disease management; and requiring
16 quality and price transparency from providers and health plans.^{1,2}

17
18 *Issues to consider and existing AMA Policy:* Unfortunately up until now the details of the
19 proposal to reward provider performance through the National Health Insurance Exchange and
20 other public programs are not described.

21
22 The AMA's has put forth 5 established principles for pay-for-performance programs: ensure
23 quality of care, foster the patient/physician relationship, offer voluntary physician participation,
24 use accurate data and fair reporting, and provide fair and equitable program incentives.

25
26 *Next steps:* Given that the value of a pay-for-performance program depends largely upon the
27 endpoints and methods used to measure performance, it will be imperative that our AMA work
28 with the federal government to ensure that the proposal to reward provider performance through
29 the National Health Insurance Exchange and other public programs is consistent with our AMA's
30 *Principles for Pay-for-Performance* and *Guidelines for Pay-for-Performance*.

31
32 Other investments

33 *The proposed plan:* The proposal also includes expansion of funding to improve the primary
34 care provider and public health practitioner workforce, including loan repayments, improved
35 reimbursement, and training grants.^{1,2}

36
37 *Issues to consider and existing AMA policy:* there is an increasing shortage of primary care
38 providers in the U.S.¹¹ The AMA has policy in place to enhance primary care as a career choice,
39 including via loan repayment programs.

40
41 *Next steps:* that our AMA work with the federal government to help develop the details of the
42 proposal to expand funding to improve the primary care provider and public health practitioner
43 workforce, including via loan repayments, improved reimbursement, and training grants.

44
45
46 IV. Conclusion

47
48 This is a unique period in our nation's history as there exists not only a universal recognition of
49 the need for healthcare reform, but their also appears to exist the political will to actually make
50 something happen. It is the hope of the Legislative and Advocacy committee that this report will
51 in part frame our perspective on the new President's healthcare reform plan and lead to
52 thoughtful action. We conclude with the following recommendations.

1 III. Recommendations

- 2
- 3 1. That our AMA continue to advocate for health system reform which makes health
4 insurance coverage accessible for all U.S. citizens
 - 5
 - 6 2. That our AMA support the proposal to require all children to have health insurance as a
7 strategic priority, and
 - 8
 - 9 3. That our AMA advocate for sufficient federal subsidy or tax credit amounts so that all
10 U.S. citizens can afford to purchase health insurance.
 - 11
 - 12 4. That our AMA support the proposed requirement for private insurers that children up to
13 age 25 could continue family coverage through their parents' plan.
 - 14
 - 15 5. That our AMA work with the federal government to ensure that if federal programs are to
16 be expanded, that proper checks and balances are in place to ensure that re-
17 imbursements reflect the actual cost of care and that patient access is not limited.
 - 18
 - 19 6. That our AMA ensure that under the National Health Insurance Exchange (or any similar
20 proposed program) that participating insurers provide high quality, transparent services,
21 and that their reimbursements reflect the actual cost of care.

22
23 Acknowledgements

24
25 The AMA Resident and Fellow Section 2008-09 Legislative Advocacy Committee is:

26 Christian Shults, MD, Chair

27 Brooke Erin Albright, MD

28 Alexander Ding, MD

29 Pamela Hackert, MD

30 Shaun Patel, MD

31 Stephen Patrick, MD, MPH

32 Claudia Reardon, MD

33 Kimberly Ruscher, MD

34 Liaison from the RFS Governing Council: Stephen Sherick, MD

35
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20
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24 25 **Relevant Policy:**

26 27 **H-165.904 Universal Health Coverage**

28 Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent
29 and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its
30 territories; (2) seeks federal legislation that would require the federal government to provide
31 financial support to any individuals, organizations, and institutions providing legally-mandated
32 health care services to foreign nationals and other persons not covered under health system
33 reform; and (3) continues to assign a high priority to the problem of the medically uninsured and
34 underinsured and continues to work toward national consensus on providing access to
35 adequate health care coverage for all Americans (Sub. Res. 138, A-94; Appended: Sub. Res.
36 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07)

37 38 **H-290.971 Expanding Enrollment for the State Children's Health Insurance Program** 39 **(SCHIP)**

40 Our AMA continues to support: a. health insurance coverage of all children as a strategic
41 priority; b. efforts to expand coverage to uninsured children who are eligible for the State
42 Children's Health Insurance Program (SCHIP) and Medicaid through improved and streamlined
43 enrollment mechanisms; c. the reauthorization of SCHIP in 2007; and d. supports the use of
44 enrollment information for participation in the Special Supplemental Nutrition Program for
45 Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as
46 documentation for SCHIP eligibility in order to allow families to avoid duplication and the
47 cumbersome process of re-documenting income for child health coverage. (Res. 118, A-07;
48 CMS Rep. 1, A-07)

49 50 **H-478.993 Implementing Electronic Medical Records**

51 It is the policy of our AMA that public and private insurers should not require the use of
52 electronic medical records. (Sub. Res. 707, A-06; Reaffirmation A-07)

1
2 **H-450.947 Pay-for-Performance Principles and Guidelines**

3 (1) The following Principles for Pay-for-Performance and Guidelines for Pay-for-Performance
4 are the official policy of our AMA.

5 **PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS**

6 Physician pay-for-performance (PFP) programs that are designed primarily to improve the
7 effectiveness and safety of patient care may serve as a positive force in our health care system.
8 Fair and ethical PFP programs are patient-centered and link evidence-based performance
9 measures to financial incentives. Such PFP programs are in alignment with the following five
10 AMA principles:

11 1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient
12 care as their most important mission. Evidence-based quality of care measures, created by
13 physicians across appropriate specialties, are the measures used in the programs. Variations in
14 an individual patient care regimen are permitted based on a physician's sound clinical judgment
15 and should not adversely affect PFP program rewards. 2. Foster the patient/physician
16 relationship - Fair and ethical PFP programs support the patient/physician relationship and
17 overcome obstacles to physicians treating patients, regardless of patients' health conditions,
18 ethnicity, economic circumstances, demographics, or treatment compliance patterns. 3. Offer
19 voluntary physician participation - Fair and ethical PFP programs offer voluntary physician
20 participation, and do not undermine the economic viability of non-participating physician
21 practices. These programs support participation by physicians in all practice settings by
22 minimizing potential financial and technological barriers including costs of start-up. 4. Use
23 accurate data and fair reporting - Fair and ethical PFP programs use accurate data and
24 scientifically valid analytical methods. Physicians are allowed to review, comment and appeal
25 results prior to the use of the results for programmatic reasons and any type of reporting. 5.
26 Provide fair and equitable program incentives - Fair and ethical PFP programs provide new
27 funds for positive incentives to physicians for their participation, progressive quality
28 improvement, or attainment of goals within the program. The eligibility criteria for the incentives
29 are fully explained to participating physicians. These programs support the goal of quality
30 improvement across all participating physicians.

31 **GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS**

32 Safe, effective, and affordable health care for all Americans is the AMA's goal for our health
33 care delivery system. The AMA presents the following guidelines regarding the formation and
34 implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines
35 augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders,
36 staff and members with operational boundaries that can be used in an assessment of specific
37 PFP programs.

38 **Quality of Care**

39 - The primary goal of any PFP program must be to promote quality patient care that is safe and
40 effective across the health care delivery system, rather than to achieve monetary savings.
41 - Evidence-based quality of care measures must be the primary measures used in any program.
42 1. All performance measures used in the program must be prospectively defined and developed
43 collaboratively across physician specialties. 2. Practicing physicians with expertise in the area of
44 care in question must be integrally involved in the design, implementation, and evaluation of any
45 program. 3. All performance measures must be developed and maintained by appropriate
46 professional organizations that periodically review and update these measures with evidence-
47 based information in a process open to the medical profession. 4. Performance measures
48 should be scored against both absolute values and relative improvement in those values. 5.
49 Performance measures must be subject to the best-available risk- adjustment for patient
50 demographics, severity of illness, and co-morbidities. 6. Performance measures must be kept
51 current and reflect changes in clinical practice. Except for evidence-based updates, program
52 measures must be stable for two years. 7. Performance measures must be selected for clinical

- 1 areas that have significant promise for improvement.
- 2 - Physician adherence to PFP program requirements must conform with improved patient care
- 3 quality and safety.
- 4 - Programs should allow for variance from specific performance measures that are in conflict
- 5 with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- 6 - PFP programs must be able to demonstrate improved quality patient care that is safer and
- 7 more effective as the result of program implementation.
- 8 - PFP programs help to ensure quality by encouraging collaborative efforts across all members
- 9 of the health care team.
- 10 - Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a
- 11 sufficient duration to obtain valid data in a variety of practice settings and across all affected
- 12 medical specialties. Pilot testing should also analyze for patient de-selection. If implemented,
- 13 the program must be phased-in over an appropriate period of time to enable participation by any
- 14 willing physician in affected specialties.
- 15 - Plans that sponsor PFP programs must prospectively explain these programs to the patients
- 16 and communities covered by them.
- 17 Patient/Physician Relationship
- 18 - Programs must be designed to support the patient/physician relationship and recognize that
- 19 physicians are ethically required to use sound medical judgment, holding the best interests of
- 20 the patient as paramount.
- 21 - Programs must not create conditions that limit access to improved care. 1. Programs must not
- 22 directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as
- 23 well as those with specific medical conditions, or the physicians who serve these patients. 2.
- 24 Programs must neither directly nor indirectly disadvantage patients and their physicians, based
- 25 on the setting where care is delivered or the location of populations served (such as inner city or
- 26 rural areas).
- 27 - Programs must neither directly nor indirectly encourage patient de-selection.
- 28 - Programs must recognize outcome limitations caused by patient non-compliance, and
- 29 sponsors of PFP programs should attempt to minimize non-compliance through plan design.
- 30 Physician Participation
- 31 - Physician participation in any PFP program must be completely voluntary.
- 32 - Sponsors of PFP programs must notify physicians of PFP program implementation and offer
- 33 physicians the opportunity to opt in or out of the PFP program without affecting the existing or
- 34 offered contract provisions from the sponsoring health plan or employer.
- 35 - Programs must be designed so that physician nonparticipation does not threaten the economic
- 36 viability of physician practices.
- 37 - Programs should be available to any physicians and specialties who wish to participate and
- 38 must not favor one specialty over another. Programs must be designed to encourage broad
- 39 physician participation across all modes of practice.
- 40 - Programs must not favor physician practices by size (large, small, or solo) or by capabilities in
- 41 information technology (IT). 1. Programs should provide physicians with tools to facilitate
- 42 participation. 2. Programs should be designed to minimize financial and technological barriers to
- 43 physician participation.
- 44 - Although some IT systems and software may facilitate improved patient management,
- 45 programs must avoid implementation plans that require physician practices to purchase health-
- 46 plan specific IT capabilities.
- 47 - Physician participation in a particular PFP program must not be linked to participation in other
- 48 health plan or government programs.
- 49 - Programs must educate physicians about the potential risks and rewards inherent in program
- 50 participation, and immediately notify participating physicians of newly identified risks and
- 51 rewards.
- 52 - Physician participants must be notified in writing about any changes in program requirements

1 and evaluation methods. Such changes must occur at most on an annual basis.

2 Physician Data and Reporting

3 - Patient privacy must be protected in all data collection, analysis, and reporting. Data collection
4 must be administratively simple and consistent with the Health Insurance Portability and
5 Accountability Act (HIPAA).

6 - The quality of data collection and analysis must be scientifically valid. Collecting and reporting
7 of data must be reliable and easy for physicians and should not create financial or other
8 burdens on physicians and/or their practices. Audit systems should be designed to ensure the
9 accuracy of data in a non-punitive manner. 1. Programs should use accurate administrative data
10 and data abstracted from medical records. 2. Medical record data should be collected in a
11 manner that is not burdensome and disruptive to physician practices. 3. Program results must
12 be based on data collected over a significant period of time and relate care delivered
13 (numerator) to a statistically valid population of patients in the denominator.

14 - Physicians must be reimbursed for any added administrative costs incurred as a result of
15 collecting and reporting data to the program.

16 - Physicians should be assessed in groups and/or across health care systems, rather than
17 individually, when feasible.

18 - Physicians must have the ability to review and comment on data and analysis used to
19 construct any performance ratings prior to the use of such ratings to determine physician
20 payment or for public reporting. 1. Physicians must be able to see preliminary ratings and be
21 given the opportunity to adjust practice patterns over a reasonable period of time to more
22 closely meet quality objectives. 2. Prior to release of any physician ratings, programs must have
23 a mechanism for physicians to see and appeal their ratings in writing. If requested by the
24 physician, physician comments must be included adjacent to any ratings.

25 - If PFP programs identify physicians with exceptional performance in providing effective and
26 safe patient care, the reasons for such performance should be shared with physician program
27 participants and widely promulgated.

28 - The results of PFP programs must not be used against physicians in health plan credentialing,
29 licensure, and certification. Individual physician quality performance information and data must
30 remain confidential and not subject to discovery in legal or other proceedings.

31 - PFP programs must have defined security measures to prevent the unauthorized release of
32 physician ratings.

33 Program Rewards

34 - Programs must be based on rewards and not on penalties.

35 - Program incentives must be sufficient in scope to cover any additional work and practice
36 expense incurred by physicians as a result of program participation.

37 - Programs must offer financial support to physician practices that implement IT systems or
38 software that interact with aspects of the PFP program.

39 - Programs must finance bonus payments based on specified performance measures with
40 supplemental funds.

41 - Programs must reward all physicians who actively participate in the program and who achieve
42 pre-specified absolute program goals or demonstrate pre-specified relative improvement toward
43 program goals.

44 - Programs must not reward physicians based on ranking compared with other physicians in the
45 program.

46 - Programs must provide to all eligible physicians and practices a complete explanation of all
47 program facets, to include the methods and performance measures used to determine incentive
48 eligibility and incentive amounts, prior to program implementation.

49 - Programs must not financially penalize physicians based on factors outside of the physician's
50 control.

51 - Programs utilizing bonus payments must be designed to protect patient access and must not
52 financially disadvantage physicians who serve minority or uninsured patients.

1 (2) Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid
2 Services pay-for-performance initiatives if they do not meet the AMA's "Principles and
3 Guidelines for Pay-for-Performance." (BOT Rep. 5, A-05; Reaffirmation A-06; Reaffirmed: Res.
4 210, A-06; Reaffirmed in lieu of Res. 215, A-06; Reaffirmed in lieu of Res. 226, A-06;
5 Reaffirmation I-06; Reaffirmation A-07)

6
7 **H-200.978 Loan Repayment Programs for Primary Care Careers**

8 The AMA will (1) work with federal and state governments to develop incentive programs, such
9 as loan repayment, to encourage practice in underserved areas, (2) engage in research to
10 identify all factors which deter students and physicians from choosing and remaining in primary
11 care disciplines and (3) use this information to support and implement AMA policy to enhance
12 primary care as a career choice. (BOT Rep. EEE, A-91; Reaffirmed: BOT Rep. GG, I-92;
13 Reaffirmed: CME Rep. 2, A-03; Reaffirmation I-06)