

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: _____
(I-08)

Introduced by: Resident and Fellow Section

Subject: Patient Prescriptions

Referred to: Reference Committee ___
(_____, Chair)

- 1 Whereas, Millions of Americans are taking multiple prescription medications with varying
2 instructions and frequencies; and
3
4 Whereas, As patients become older and more likely to be taking multiple medications, they are
5 also more likely to suffer from visual impairments; and
6
7 Whereas, Visually impaired patients can have difficulty adhering to medication regimens
8 because difficulty in reading labels can prevent them from following explicit instructions on
9 prescription bottles; and
10
11 Whereas, Increased font size and color coding may help facilitate recognition of medications
12 and following specific instructions regarding when and how to take medications; therefore be it
13
14 RESOLVED, That the American Medical Association work with relevant organizations to
15 improve prescription labeling for visually or otherwise impaired patients and to increase
16 awareness of available resources.
17
18 Fiscal Note: TBD
19
20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: _____
(I-08)

Introduced by: Resident and Fellow Section

Subject: Provision of Child Care by Residency and Fellowship Training Programs

Referred to: Reference Committee ____
(_____, Chair)

1 Whereas, Our AMA has recognized the importance of appropriate child care in early
2 development¹; and
3

4 Whereas, Many residents and fellows during their years of training will have children and will
5 require child care to be provided to accommodate their work schedules; and
6

7 Whereas, Medical students, residents, and fellows utilize the Freida database to compare
8 details of different training programs, including provisions of child care; and
9

10 Whereas, Our AMA has recognized the need for child care among residents and fellows and
11 recommended in 1990 that hospitals provide 24 hour child care to accommodate residents'
12 schedules^{2,3,4}; and
13

14 Whereas, It is unclear the extent to which AMA's recommendations have been implemented
15 over the intervening 18 years; therefore be it
16

17 RESOLVED, That our AMA begin collecting more comprehensive data on the provision of child
18 care services or stipends for child care by residency and fellowship programs using the Freida
19 database (Directive to Take Action); and be it further
20

21 RESOLVED, That our AMA evaluate the progress made in the provision of child care and
22 different models being utilized by training programs (Directive to Take Action).
23

24 Fiscal Note: TBD
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26

27 **Relevant AMA Policy/References:**
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29 **D-60.982 Long Term Effects of Early Abuse/Neglect on Brain Development:**

30 Our AMA will: (1) work with national organizations, e.g., American Academy of Pediatrics,
31 American Academy of Child and Adolescent Psychiatry, American College of Obstetricians and
32 Gynecologists, and others involved with early brain research, child abuse and neglect and
33 public education to make educational materials available to hospital infant and pediatric
34 personnel, physicians, parents, other child care providers and educators and the public at large;
35 (2) urge state and local medical societies to work with their legislators to put in place
36 educational, and where appropriate, support programs for those involved with infants and young
37 children, i.e., parents, students in junior and senior high school, child care providers, and early
38 childhood educators; and (3) work with the federal government and pertinent agencies to make
39 this issue--prevention of early abuse and brain damage with its devastating long term effects for

1 individuals and society--a priority of our nation. (BOT Action in response to referred for decision
2 Res. 526, A-02)

3
4 **H-215.985 Child Care in Hospitals:**

5 Our AMA: (1) strongly encourages hospitals to establish and support child care facilities; (2)
6 encourages that priority be given to children of those in training and that services be structured
7 to take their needs into consideration; (3) supports informing the AHA, hospital medical staffs,
8 and residency program directors of these policies; and (4) supports studying the elements of
9 quality child care and availability of child care on a 24-hour basis. (BOT Rep. J, I-90;
10 Reaffirmed: Sunset Report, I-00)

11
12 **H-525.998 Women in Organized Medicine:**

13 Our AMA: (1) reaffirms its policy advocating equal opportunities and opposing sex discrimination
14 in the medical profession; (2) supports the concept of increased tax benefits for working
15 parents; (3) (a) supports the concept of proper child care for families of working parents; (b)
16 reaffirms its position on child care facilities in or near medical centers and hospitals; (c)
17 encourages business and industry to establish employee child care centers on or near their
18 premises when possible; and (d) encourages local medical societies to survey physicians to
19 determine the interest in clearinghouse activities and in child care services during medical
20 society meetings;
21 (4) reaffirms its policy supporting flexibly scheduled residencies and encourages increased
22 availability of such programs; and (5) supports that the AMA Guidelines for Establishing Sexual
23 Harassment Prevention and Grievance Procedures be updated by the AMA Women Physicians
24 Congress, and forwarded to the House of Delegates for approval, and include not only
25 resources for training programs but also private practice settings. To facilitate wide distribution
26 and easy access, the Guidelines will be placed on the AMA Web site. (BOT Rep. T, A-81;
27 Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation A-00; Modified: CME Rep. 3, A-03)

28
29 **H-9.035 Gender Discrimination in the Medical Profession:**

30 Physician leaders in medical schools and other medical institutions should take immediate steps
31 to increase the number of women in leadership positions as such positions become open. There
32 is already a large enough pool of female physicians to provide strong candidates for such
33 positions. Also, adjustments should be made to ensure that all physicians are equitably
34 compensated for their work. Women and men in the same specialty with the same experience
35 and doing the same work should be paid the same compensation. Physicians in the workplace
36 should actively develop the following: (1) retraining or other programs which facilitate the re-
37 entry of physicians who take time away from their careers to have a family; (2) on-site child care
38 services for dependent children; and (3) policies providing job security for physicians who are
39 temporarily not in practice due to pregnancy or family obligations. Physicians in the academic
40 medical setting should strive to promote the following: (1) extension of tenure decisions through
41 "stop the clock" programs, relaxation of the seven year rule, or part-time appointments that
42 would give faculty members longer to achieve standards for promotion and tenure; (2) more
43 reasonable guidelines regarding the appropriate quantity and timing of published material
44 needed for promotion or tenure that would emphasize quality over quantity and that would
45 encourage the pursuit of careers based on individual talent rather than tenure standards that
46 undervalue teaching ability and overvalue research; and (3) fair distribution of teaching, clinical,
47 research, administrative responsibilities, and access to tenure tracks between men and women.
48 Also, physicians in academic institutions should consider formally structuring the mentoring
49 process, possibly matching students or faculty with advisors through a fair and visible system.
50 Where such policies do not exist or have not been followed, all medical workplaces and
51 institutions should create strict policies to deal with sexual harassment. Grievance committees
52 should have broad representation of both sexes and other groups. Such committees should

1 have the power to enforce harassment policies and be accessible to those persons they are
2 meant to serve. Grantors of research funds and editors of scientific or medical journals should
3 consider blind peer review of grant proposals and articles for publication to help prevent bias.
4 However, grantors and editors will be able to consider the author's identity and give it
5 appropriate weight. (II, VII) Issued June 1994 based on the report "Gender Discrimination in the
6 Medical Profession," adopted June 1993 (Women's Health Issues. 1994; 4: 1-11)
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Resolution:
(I-08)

Introduced by: Resident and Fellow Section

Subject: Recognizing the Adverse Effects of Defensive Medicine

Referred to: Reference Committee _____
(_____, Chair)

1 Whereas, Defensive medicine is defined as medical practices, such as ordering excess
2 diagnostic testing, treatment, hospitalization, or consultation, that may perceivably exonerate
3 physicians from liability without significant benefit to patients; and
4

5 Whereas, Defensive medicine may also be defined as when physicians curtail particular aspects
6 of their practice, such as risky operations or labor and delivery, out of fear of liability risk; and
7

8 Whereas, The prevalence of the practice of defensive medicine by physicians has been
9 estimated as high as 92%¹; and
10

11 Whereas, The costs of defensive medicine to the health care system are estimated at nearly
12 \$120 billion per year (in 2007 dollars)²; and
13

14 Whereas, Defensive measures contribute marginal to no benefit to the patient, while costing the
15 health care system scarce resources, and exposing patients to the adverse effects of excessive
16 work-ups and complications of defensive therapeutics; and
17

18 Whereas, Comprehensive and sensible tort reforms, including caps on non-economic damages,
19 have shown effectiveness in mitigating liability environments in various states including
20 California and Texas; and
21

22 Whereas, Improvements in liability environments have been associated with decreased rates of
23 defensive medical practices³, therefore be it
24

25 RESOLVED, that the AMA affirm that defensive medicine exists in many forms with variable and
26 difficult to quantify economic consequences for patients, physicians, third-party payers,
27 insurance providers and other parties involved in the delivery of health care; and be it further
28

29 RESOLVED, that the AMA affirm that defensive medicine in its many forms may result in
30 adverse health effects on patients through exposure to unnecessary risk from tests and
31 procedures as well as limited access to health care resources; and be it further
32

33 RESOLVED, that the AMA continue to work with other interested parties through legislative and
34 public awareness activities to advocate for medical liability reform which would minimize the
35 practice of defensive medicine.

¹ Studdert DM, Mellow MM, Sage WM, et al. Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment. *JAMA*. June 05, Vol 293. No 21.

² Lewin-VHI, Inc. Estimating the Costs of Defensive Medicine, report prepared for MMI Companies, Inc. Fairfax, VA. Jan 27, 1993.

³ Dubay L, Kaestner R, Waidmann T. The impact of malpractice fears on cesarean section rates. *J Health Econ*. 18(1999):491-522.