



## Resident and Fellow Section

# Summary of Actions

32<sup>nd</sup> Interim Business Meeting  
November 6-8, 2008  
Orlando World Center Marriot  
Orlando, Florida

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Refer to the AMA PolicyFinder for official policy of the Association."*

## American Medical Association-Resident and Fellow Section Summary of Actions (I-08)

The 2008 Interim Meeting of the American Medical Association - Resident and Fellow Section (AMA-RFS) was held November 6-8, 2008 at the Orlando World Center Marriot in Orlando, Florida. The RFS Assembly considered 13 items of business: 7 resolutions and 6 reports. Actions taken by the Assembly are outlined below in three sections: I) Resolutions, II) Reports, III) RFS Resolutions Submitted to the AMA House of Delegates at I-08, and IV) Actions taken by the AMA House of Delegates on previously submitted RFS reports and resolutions.

### I. RFS RESOLUTIONS

RFS Resolution	Action	Policy
Resolution 1 –Interoperability of Medical Devices	ADOPTED	RESOLVED, That the AMA adopt the following statement on the Interoperability of Medical Devices: "The AMA believes that intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. The AMA also recognizes that, as in all technological advances, interoperability poses safety and medico legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve maximum patient safety, efficiency, and outcome benefit."
Resolution 2 – AMA Membership Eligibility for U.S. Citizen Medical Students and Residents/Fellows Training Abroad	REFERRED	RESOLVED, That the AMA investigate the possibility of creating a special category of membership for U.S. citizens who are undergoing their medical training abroad.
Resolution 3 – Developing a Mentoring Program for New AMA-RFS Attendees	ADOPTED AS AMENDED	RESOLVED, That the AMA-RFS <del>Membership Committee</del> work to create a mentoring program to welcome new attendees to the section's meetings including, but not limited to, linking mentors and mentees of the same region to sit near each other during RFS business, apprising the mentee of evening social activities, and contacting the mentee before the subsequent meeting.
Resolution 4– Support of Calorie Labeling in Restaurants	ADOPTED AS AMENDED	RESOLVED, That the <u>AMA</u> work with state medical associations, <del>all</del> state restaurant associations, state departments of health, and other interested parties <del>nationwide</del> , to create a method for displaying <u>nutritional information calories</u> on restaurant menus and menu boards for all food and beverage items.

RFS Resolution	Action	Policy
Resolution 5 – Resolution Radiation Oncology is not an Ancillary Service	ADOPTED AS AMENDED	<p>RESOLVED, That the AMA affirm that <del>any designation of radiation therapy oncology</del> as is not ancillary <del>to any service is inaccurate</del>; and be it further</p> <p>RESOLVED, <u>that the AMA affirm that any designation of radiation therapy as an ancillary service is inaccurate; and be it further</u></p> <p>RESOLVED, That the AMA oppose any legal <del>or other</del> designation of Radiation <del>therapy Oncology</del> as an "<u>in-office ancillary service.</u>"</p> <p><u>RESOLVED, That this resolution be forwarded immediately for consideration by the AMA-HOD at I-08.</u></p>
Resolution 6 – Eliminating Questions Regarding Marital Status, Childbearing and Dependent Children During the Residency and Fellowship Application Process	ADOPTED AS AMENDED	<p><del>RESOLVED, That our AMA-RFS study the problem of inappropriate gender based questions regarding marital status, childbearing and dependent children during the residency and fellowship application process, and be it further</del></p> <p>RESOLVED, That our AMA and AMA-RFS oppose questioning residency or fellowship applicants regarding marital status, dependents, <del>or</del> plans for marriage or children, <u>sexual orientation, and religion</u> and be it further</p> <p>RESOLVED, That our AMA work with the ACGME, NRMP and other interested parties to eliminate questioning about marital and dependent status, <del>or</del> future plans for marriage or children, <u>sexual orientation, and religion</u> during the residency and fellowship application process, and be it further</p> <p>RESOLVED, That our AMA-RFS report back on this issue at I-09</p>
Resolution 7 – Resident and Fellow Physician’s Bill of Rights	REFERRED	RESOLVED, That our AMA create from this <i>Bill of Rights</i> an executive summary which is succinct and imminently readable and then distribute that summary to all U.S. residency and fellowship training programs asking that it be prominently displayed in whatever area may be most common to the majority of its Residents or Fellows.

## II. RFS REPORTS

Report	Introduced by	Action	Policy (if Action Report)
Report C – Sunset Mechanism: 1998 Actions to Reaffirm	RFS Governing Council	ADOPTED	Recommendations adopted and the remainder of the report filed.
Report D – Sunset Mechanism: 1998 Actions to Rescind	RFS Governing Council	ADOPTED	Recommendations adopted and the remainder of the report filed.
Report E – Final Credentialing for Physicians who Transfer Training Programs and Graduate from the Final Residency Program	RFS Governing Council	ADOPTED	Reaffirmation of current AMA policy in lieu of adopting Resolution 1: Final Credentialing for Physicians who Transfer Training Programs and Graduate from the Final Residency Program (AMA-RFS, A-08)
Report F – Expanding Underrepresented Minority Voices in the AMA-RFS	RFS Governing Council	ADOPTED	<ol style="list-style-type: none"> <li>1. That the AMA-RFS create bylaws to specifically and systematically outline how a minority physician organization may gain representation in the RFS national assembly;</li> <li>2. That the AMA-RFS research the major underrepresented minority physician organizations with a focus on the level of involvement of resident and fellow members in each organization, on the percentage of AMA members in each organization, and on the level to which each minority physician organization desires to be involved with the AMA-RFS;</li> <li>3. That the AMA-RFS leadership work with the Specialty and Service Society (SSS) to determine the needed steps that minority physician organizations would have to take to become seated members of the AMA-HOD;</li> <li>4. That the AMA-RFS report back to the RFS assembly on this issue at A-09.</li> </ol>

Report	Introduced by	Action	Policy (if Action Report)
<p>Report G – Bylaws Changes for AMA-RFS Sectional Delegates and Alternate Delegates Election Procedures and Vacancies</p>	<p>AMA-RFS Committee on Long Range Planning</p>	<p>ADOPTED</p>	<p>1. That the AMA-RFS IOP be in Section VI.G.5.a. as following to reflect the Plurality voting system adopted at the 2008 Annual meeting:</p> <p>i. Balloting. All nominees for the office of Sectional Delegate shall be listed on a single ballot with their endorsing society. The ballot will contain clear voting instructions with a brief explanation of ballot counting procedures. The voter may select up to and including the number of candidate positions. Ballots will be counted and delegates selected based on an approval-based, plurality-at-large voting system. Only nominees receiving a simple majority of the legal votes cast shall be elected.</p> <p>ii. Limitations. If there is more than one nominee from an endorsing state or specialty society, then only the nominee from that endorsing society who has a majority and who has the most votes shall be elected. All other nominees from that society shall be eliminated from the remaining counting of ballots. This process will continue throughout the counting of ballots to ensure that there is only one RFS Sectional Delegate per endorsing state and specialty society.</p> <p>iii. Unfilled Seats. If there are unfilled Sectional Delegate seats after the election, the ballot counting process will begin again, allowing only one additional Sectional Delegate per endorsing state/specialty society. This process will continue through as many counting rounds as needed until all Sectional Delegate seats are filled. With each subsequent counting round, the limitation of Sectional Delegate from a given state or specialty society shall increase by one.</p> <p>iv. Run-Off Elections. If there are two or more candidates that tie for the highest number of votes, though there are fewer positions available than tied candidates, a Run-Off election will occur. The candidates who tied will be placed on a subsequent ballot with all other candidates removed, and a subsequent vote shall take place. The candidate(s) who receive(s) the highest number of votes, with a majority of legal votes cast, shall be elected. If in any round, no nominee receives a majority, the nominee(s) with the fewest votes shall be eliminated. This process will continue until all Sectional Delegate and Alternate Delegate seats are filled.</p>

Report	Introduced by	Action	Policy (if Action Report)
			<p>2. That the AMA-RFS IOP be changed in Section VI as following to reflect the issues related to vacancies in the Sectional Delegate/Alternate Delegate position:</p> <p><b>I. Vacancies.</b></p> <p>1. Vacancy to be filled at the next meeting. In the case that a vacancy in the position of Sectional Delegate or Alternate Delegate occurs one meeting prior to which the term is to be fulfilled, the Governing Council shall inform the assembly of the number of vacancies and an election according to the procedures defined in RFS Internal Operating Procedures VI.G shall occur at the following meeting of the RFS Assembly.</p> <p>2. Other Vacancies. Should a vacancy arise in the position of Sectional Delegate for which an election will not take place prior to the start of the meeting during which any portion of the term is to be fulfilled elected alternate delegates shall assume the role of delegates. Should there still remain Delegate vacancies, these, along with the alternate delegate vacancies shall be filled by a nomination and majority vote of the members of the RFS Governing Council who are present. These Delegates and Alternate Delegates shall not be subject to the requirement of state or specialty society endorsement.</p>

Report	Introduced by	Action	Policy (if Action Report)
Report H – President Barack Obama’s Health Care Plan	AMA-RFS Legislative Advocacy Committee	ADOPTED AS AMENDED	<ol style="list-style-type: none"> <li>1. That our AMA-RFS continue to advocate for health system reform which makes health insurance coverage accessible for all U.S. citizens</li> <li>2. That our AMA-RFS support the proposal to require all children to have health insurance as a strategic priority, and</li> <li>3. That our AMA-RFS advocate for sufficient federal subsidy or tax credit amounts so that all U.S. citizens can afford to purchase health insurance.</li> <li>4. That our AMA-RFS support the proposed requirement for private insurers that children up to age 25 could continue family coverage through their parents’ plan.</li> <li>5. That our AMA-RFS work with the federal government to ensure that if federal programs are to be expanded, that proper checks and balances are in place to ensure that reimbursements reflect the actual cost of care and that patient access is not limited.</li> <li>6. That our AMA-RFS ensure that under the National Health Insurance Exchange (or any similar proposed program) that participating insurers provide high quality, transparent services, and that their reimbursements reflect the actual cost of care.</li> </ol> <p>RESOLVED: That our AMA support <del>the</del> <u>requiring</u> all children to have health insurance as a strategic priority.</p>

### III. RFS RESOLUTIONS SUBMITTED TO THE AMA HOUSE OF DELEGATES (I-08)

<b>HOD Resolution</b>	<b>Action</b>	<b>Policy</b>
RESOLUTION 610 – Health Insurance for Children	ADOPTED AS AMENDED	RESOLVED That our American Medical Association support requiring all children to have adequate health insurance as a strategic priority. (New HOD Policy)
RESOLUTION 842 – Radiation Therapy Is Not an Ancillary Service	REFERRED FOR DECISION	RESOLVED, That the AMA affirm that radiation therapy is not ancillary to any service; and be it further  RESOLVED, that the AMA affirm that any designation of radiation therapy as an ancillary service is inaccurate; and be it further  RESOLVED, That the AMA oppose any legal or other designation of radiation therapy as an "in-office ancillary service."
RESOLUTION 822 –Recognizing the Adverse Effects of Defensive Medicine	REAFFIRMED	RESOLVED, that the AMA affirm that defensive medicine exists in many forms with variable and difficult to quantify economic consequences for patients, physicians, third-party payers, insurance providers and other parties involved in the delivery of health care; and be it further  RESOLVED, that the AMA affirm that defensive medicine in its many forms may result in adverse health effects on patients through exposure to unnecessary risk from tests and procedures as well as limited access to health care resources; and be it further  RESOLVED, that the AMA continue to work with other interested parties through legislative and public awareness activities to advocate for medical liability reform which would minimize the practice of defensive medicine.
RESOLUTION 914 - Patient Prescriptions	ADOPTED	RESOLVED, That the American Medical Association work with relevant organizations to improve prescription labeling for visually or otherwise impaired patients and to increase awareness of available resources.

**IV. Actions taken by the AMA House of Delegates on previously submitted RFS reports and resolutions**

HOD Resolution	Action	Policy
<p>COUNCIL ON MEDICAL EDUCATION REPORT 4 – Securing Medicare GME Funding For Research and Ambulatory Non-Hospital-Based Outside Rotations During Residency</p>	<p>ADOPTED AS AMENDED</p>	<ol style="list-style-type: none"> <li>1. Reaffirm AMA Policies H-305.929 and D-305.967 on the financing of medical education, including that diversified sources of funding (including Medicare, Medicaid, the Department of Defense, the Veterans Administration, and National Institutes of Health) should be available to support medical schools’ multiple missions, including education, research, and clinical service; and that reliance on any particular revenue source should not jeopardize the balance among a medical school’s missions. (Reaffirm HOD Policy)</li> <li>2. Advocate for the Centers for Medicare and Medicaid Services (CMS) (both federal Medicare and federal/state Medicaid) funding for the time residents and fellows spend in research, <u>didactic activities</u>, and extramural educational activities required for the Accreditation Council for Graduate Medical Education (ACGME) accreditation during their training. (Directive to Take Action)</li> <li>3. Continue to work with organizations such as the Association of American Medical Colleges (AAMC) and the Council on Graduate Medical Education (COGME), to make recommendations to change current Graduate Medical Education (GME) funding regulations during residency training, which currently limit funding for research, extramural educational opportunities, and flexible GME training programs and venues. (Directive to Take Action)</li> <li>4. Monitor any public and/or private efforts to change the financing of medical services (health system reform) so as to advocate for adequate and appropriate funding of GME. (Directive to Take Action)</li> <li>5. Prepare a Council on Medical Education report for the 2009 Interim Meeting that broadly addresses issues of GME funding that includes examples of successful state and regional innovations. (Directive to Take Action)</li> <li>6. Advocate for funding for training physician researchers from sources in addition to CMS such as the National Institutes of Health, the Agency for Healthcare Research and Quality, the Veterans Administration, and other agencies, and reaffirm policies H-460.982 and H- 460.930. (Directive to Take Action)</li> </ol>

HOD Resolution	Action	Policy
<p>COUNCIL ON MEDICAL EDUCATION REPORT 5 - Use of At-Home Call By Residency Programs</p>	<p>ADOPTED AS AMENDED</p>	<ol style="list-style-type: none"> <li>1. That our American Medical Association encourage the Accreditation Council for Graduate Medical Education to collect data on at-home call by specialty from both program directors and from residents and fellows and to release these aggregate data annually to the Graduate Medical Education community. (Directive to Take Action)</li> <li>2. That our AMA and the ACGME collaborate on a survey (similar to those conducted by the AMA in 1989 and 1999) on the educational environment of resident physicians, encompassing all aspects of duty hours, including at-home call. (Directive to Take Action)</li> <li>3. That our AMA ask that the Council on Medical Education incorporate a review of at-home call issues in the duty hours follow-up report due at the 2010 Annual Meeting. (Directive to Take Action) CME Rep. 5-I-08 -- page 6</li> <li>4. That our AMA encourage the ACGME to change its program requirements to account for all duty hours, regardless of setting, in calculating the 80-hour work week, while at the same time <u>define "at-home call" and its appropriate or inappropriate uses</u>, allowing for flexible solutions from one specialty to the next, <u>with a report back to the House of Delegates</u>. (Directive to Take Action)</li> <li>5. That our AMA encourage the ACGME and the GME community to examine the effects of the increased use of at-home call on resident education and supervision and develop appropriate standards to ensure that appropriate education and supervision is maintained, regardless of the setting. (Directive to Take Action).</li> </ol>