2011 AMA-RFS Interim Meeting Resolutions and Reports

Resolution 1 - US Farm Subsidies

Resolution 2 - Prescription Drug Shortages: A National Emergency

Resolution 3 - Opting Out of Health Information Exchanges

Resolution 4 - Preserving the Opportunity to Moonlight

Resolution 5 - Health Policy Education in Medical School and Residency

Resolution 6 - Making GME Financing and Reform a Priority for AMA

Resolution 7 - Elimination of the Secured Examination Requirement for Maintenance of Certification

Resolution 8 - Board Certification of Physician and Surgeons

Resolution 9 - Transparency in Consumer Communications

Resolution 10 - Reimbursement Data for Non-physician Health Care Providers from the Center of Medicare & Medicaid Services

Report C - AMA-RFS Sunset Mechanism: 2001 Actions to Reaffirm

Report D - AMA-RFS Sunset Mechanism: 2001 Actions to Rescind

Report E - Sectional Delegate Election Procedures

Report F - Reimbursement for Phone Consultations

Report G - Report on the Deficiency in Medical Education Relating to Autopsy

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1
(I-11)

Introduced by: Stephen Darrow, MD, Virginia Hernandez, MD, Maya Babu, MD, Charles Smittkamp, MD and Sara Dyrstad, MD

Subject: US Farm Subsidies

Referred to: Reference Committee

---

1 Whereas, Several AMA policies advocate for food system reform; be it by sustainable food
2 practice[1], education regarding obesity[2] and nutrition[3,4,5], consumer level price equalization
3 between nutrition-dense and nutrition-poor foods[6], reducing disparity of access to vegetables[7],
4 limiting the amount of added caloric sweeteners[8], improving food safety[9], education regarding
5 excess sodium[10], greater oversight of Bisphenol A[11], urging termination of non-therapeutic
6 antibiotic usage in agriculture[12], and recognizing the anthropogenic negative effects on the
7 environment that create ill health and supports their respective solutions[13,14,15];
8
9 Whereas, Approximately 25% of the present US Farm Bill [16], through various crop specific
10 subsidies, creates a financially beneficial environment for non-sustainable foods; creation of
11 low-cost, nutrition-poor foods and sweeteners that necessitate large education campaigns
12 against the resultant over-consumption; decreased access to vegetables relative to other foods;
13 and large-scale agricultural practices that decrease food safety, utilize non-therapeutic
14 antibiotics, excess sodium for processing, Bisphenol A for packaging, and vast transportation /
15 fertilizer / pesticide networks creating anthropogenic environmental impacts;
16
17 Whereas, APHA US Farm Bill reform policy number 20072[17] urges Congress to shift federal
18 subsidies to products low in fat, cholesterol, sodium, and sugar; urges the federal protection of
19 nutrition interests over agricultural interests, and prevents federal preemption of more stringent
20 local standards for limiting fats, saturated fat, cholesterol, sugar and salt; and
21
22 Whereas, If the US Farm Bill is not reformed by the Super Committee[18] to reflect existing AMA
23 policy, the US Farm Bill will be submitted for renewal and reform in 2012 as part of the every 5
24 year cycle; therefore be it
25
26 RESOLVED, That the AMA actively lobby for reform of the US Farm Bill to reflect the above
27 preexistent AMA policy goals; be it obesity-related, environmental, energy, price equality /
28 reduction of crop specific subsidies, food safety, chemical use, education, caloric
29 overconsumption of low cost foods, antimicrobial use in livestock, and excess sodium use; and
30 be it further
31
32 RESOLVED, That the AMA work with legislators to redirect subsidies in the US Farm Bill budget
33 that perpetuate products which are high in fat, cholesterol, sodium and high fructose corn syrup
34 toward programs aimed at combating obesity; and be it further
35
36 RESOLVED, That this be forwarded immediately to AMA-HOD at I-11.
37
38

Fiscal note: TBD

References:

1. D-150.978, Sustainable Food (see below for location of AMA policy)
2. H-150.953, Obesity as a Major Public Health Program
3. H-150.993, Medical Education in Nutrition
4. H-150.995 Basic courses in Nutrition
5. H-150.996 Nutrition Courses in Medicine
6. H-150.937, Reducing the Price Disparity Between Calorie-Dense Nutrition Poor Foods and Nutrition-Dense Foods
7. H-150.944, Combating Obesity and Health Disparities
8. D150.981 The Health Effects of High Fructose Syrup
9. H-150.940, Update on the Food and Drug Administration's Efforts to Improve Food Safety
10. H-150.997 Excess Sodium in the Diet
11. H135.933 Bisphenol A
12. H-440.895 Antimicrobial Use and Resistance
13. H-135.939 Green Initiatives and the Health Care Community
14. H-135.938 Global Climate Change and Human Health
15. H-135.973 Stewardship of the Environment
16. American Public Health Association http://apha.confex.com/apha/139am/webprogram/Session33192.html
17. American Public Health Association Policy Statement Database (Policy date 11/6/2007) "Addressing Obesity and Health Disparities Through Federal Nutrition and Agricultural Policy". Available at http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1347
18. United States Congress Joint Select Committee on Deficit Reduction

Relevant AMA Poicy:

D-150.978 Sustainable Food
https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fDIR%2fD-150.978.HTM
Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through the US Farm Bill and other federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. (CSAPH Rep. 8, A-09; Reaffirmed in lieu of Res. 411, A-11)

H-150.953 Obesity as a Major Public Health Program
https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-150.953.HTM
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about

1 how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for
2 overweight and obesity during routine medical examinations and discuss with at-risk patients the health
3 consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate
4 weight maintenance or reduction efforts in their patients or refer them to a physician with special interest
5 and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a
6 desired weight and prevent inappropriate weight gain; (7) encourage physicians to become
7 knowledgeable of community resources and referral services that can assist with the management of
8 overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized
9 medicine and the health insurance industry to develop coding and payment mechanisms for the
10 evaluation and management of obesity. (CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep.
11 1, A-09; Reaffirmation A-10; Reaffirmation I-10)
12
13 **H-150.993 Medical Education in Nutrition**
14 https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-
15 assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-150.993.HTM
16 The AMA recommends that instruction on nutrition be included in the curriculum of medical schools in the
17 United States. (Sub. Res. 82, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: CME Rep. 3, I-97;
18 Reaffirmed: CME Rep. 2, A-07)
19
20 **H-150.995 Basic Courses in Nutrition**
21 https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-
22 assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-150.995.HTM
23 Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate
24 levels. (Sub. Res. 116, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00;
25 Reaffirmed: CME Rep. 2, A-11)
26
27 **H-150.996 Nutrition Courses in Medicine**
28 https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-
29 assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-150.996.HTM
30 Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools and
31 that the LCME work toward enhancement of the teaching of nutrition in medical schools. (Sub. Res. 66, I-
32 77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)
33
34 **H-150.937 Reducing the Price Disparity Between Calorie-Dense, Nutrition-Poor Foods and**
35 **Nutrition-Dense Foods**
36 https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-
37 assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-150.937.HTM
38 Our AMA supports: (1) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and
39 naturally nutrition-dense foods to improve health in economically disadvantaged populations by
40 encouraging the expansion, through increased funds and increased enrollment, of existing programs that
41 seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of
42 the Women, Infants, and Children program; and (2) the novel application of the Farmer's Market Nutrition
43 Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply
44 program models that incentivize the consumption of naturally nutrition-dense foods in wider food
45 distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.
46 (Res. 414, A-10)
47
48 **H-150.944 Combating Obesity and Health Disparities**
49 https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-
50 assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-150.944.HTM
51 Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the
52 health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and
53 healthful nondairy beverages in school lunches and food assistance programs; and (3) ensure that
54 federal subsidies encourage the consumption of products low in fat and cholesterol. (Res. 413, A-07)
55
56 **D-150.981 The Health Effects of High Fructose Syrup**

https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fDIR%2fD-150.981.HTM
Our AMA:
(1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS;
(2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other sweeteners, and evaluation of the mechanism of action and relationship between fructose dose and response; and
(3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added caloric sweeteners in their diet. (CSAPH Rep. 3, A-08)

H-150.940 Update on the Food and Drug Administration's Efforts to Improve Food Safety
https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-150.940.HTM
Our AMA: (1) supports regulatory and legislative changes that will empower the Food and Drug Administration (FDA) to implement its “Transforming Food Safety Initiative” built upon the three core principles of (a) prioritizing prevention, (b) strengthening surveillance and enforcement, and (c) improving response and recovery; (2) will monitor the implementation of the "Transforming Food Safety Initiative," and provide feedback to the FDA as necessary; and (3) urges phy sicians to remain informed on the diagnosis and management of foodborne illnesses and to report suspected cases of foodborne illnesses to their local public health authority. (CSAPH Rep. 3, A-10)

H-150.997 Excess Sodium in the Diet
https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/ama1/pub/upload/mm/PolicyFinder/policyfiles/HnE/H-150.997.HTM
Our AMA supports continued use of its publications to inform the public of foods containing high sodium levels, and the relationship of sodium intake to the potential development and control of hypertension. (Sub. Res. 22, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Res. 408, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

H-135.933 Bisphenol A
https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-135.933.HTM
Our AMA: 1) supports a shift to a more robust, science-based, and transparent federal regulatory framework for oversight of bisphenol A (BPA); 2) encourages ongoing industry actions to stop producing BPA-containing baby bottles and infant feeding cups, support bans on the sale of such products, and urge the development and use of safe, nonharmful alternatives to BPA for the linings of infant formula cans and other food can linings; and 3) recognizes BPA as an endocrine-disrupting agent and urge that BPA-containing products with the potential to increase human exposure to BPA be clearly identified. (CSAPH Rep. 5, A-11

H-440.895 Antimicrobial Use and Resistance
https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-440.895.HTM
Our AMA is opposed to the use of antimicrobials at non-therapeutic levels in agriculture, or as pesticides or growth promoters, and urges that non-therapeutic use in animals of antimicrobials (that are also used in humans) should be terminated or phased out based on scientifically sound risk assessments. (Res. 508, A-01; Reaffirmed: CSAPH Rep. 1, A-11)

H-135.939 Green Initiatives and the Health Care Community
https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-135.939.HTM
Our AMA supports: (1) responsible waste management policies, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5)

community-wide adoption of “green” initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. (CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10)

H-135.938 Global Climate Change and Human Health

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change’s fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA’s Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. (CSAPH Rep. 3, I-08)

H-135.973 Stewardship of the Environment

https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fdoc%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-135.973.HTM

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation. (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support. (CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 2
(I-11)

Introduced by: Medical Society of the State of New York Resident and Fellow Section

Subject: Prescription Drug Shortages: A National Emergency

Referred to: Reference Committee

---

1 Whereas, The safety and well-being of the populace is crucial to the safety of the country; and
2
3 Whereas, In recent years, there have been shortages of necessary medicines; and
4
5 Whereas, Some medicines are not profitable for American drug companies to produce; and
6
7 Whereas, Many medicines are produced in other countries; and
8
9 Whereas, The safety and supply of medicines from other countries is difficult to control; and
10
11 Whereas, Unsafe and unverifiable medicines and medicine shortages are a threat to the
12 security and health of the people of the United States of America; and
13
14 Whereas, Emergency reserves of certain foods and fuels crucial to the nation are currently
15 maintained; and
16
17 Whereas, The Medical Society of the State of New York has publicly declared the problem of
18 unsafe and unverifiable medicines and medicine shortages a public health emergency in New
19 York; and
20
21 Whereas, The Medical Society of the State of New York is currently working with the State's
22 Department of Health and PhRMA and its companies to address this serious problem; therefore
23 be it
24
25 RESOLVED, That our AMA study the critical issue of unsafe and unverifiable medicines and
26 medicine shortages in the United States and report back to the AMA-HOD at A-12 with short
27 and long term remedies for mitigating and/or solving the problem; and be it further
28
29 RESOLVED, That our AMA immediately communicate its concern to the White House, the
30 Institute of Medicine and HHS, and ask that the Administration join with the AMA to immediately
31 address this public health emergency.

Fiscal Note: Estimated at greater than $25,000 for study

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 3
(I-11)

Introduced by: American Society of Interventional Pain Physicians; Iowa Medical Society; Maryland State Medical Society; Minnesota Medical Association; Missouri State Medical Association; Nebraska Medical Association; North Dakota Medical Association; South Dakota Medical Association; Wisconsin Medical Society

Subject: Opting Out of Health Information Exchanges

Referred to: Reference Committee

---

1 Whereas, There is a large healthcare burden associated with the transfer of medical information
2 from provider to provider which has driven a state and federal effort toward the creation and
3 implementation of health information exchanges; and
4
5 Whereas, The creation of such exchanges may lead to the violation of patient privacy, the
6 dissemination of protected health information, or the loss of personal identification information
7 thereby making patients more vulnerable to injury through identity theft; and
8
9 Whereas, There have already been multiple cases of large scale losses of patient records,
10 including protected health information and personal identification information, both through
11 breeches of internet security systems and through the irresponsible handling of such data (ie
12 having open accessible and unprotected servers) on existing insurance provider networks; and
13
14 Whereas, The federal government and in some cases individual states are moving toward the
15 creation of health information exchanges; and
16
17 Whereas, In most cases patients currently do not have the option to opt-out of having their
18 records kept on health information exchanges; and
19
20 Whereas, There may be a motion to displace potential monetary losses by patients' opting-out
21 of such exchanges onto such patients; therefore be it
22
23 RESOLVED, That our AMA work toward legislation at the federal level allowing patients to opt
24 out of inter-health system (not intra-health system) information exchanges, as well as state and
25 federal level health information exchanges, at no cost to patients that choose this option.

Fiscal note: Estimated at greater than $10,000 for advocacy and communication.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 4
(I-11)

Introduced by: Justin Bachmann, MD, Maya Babu, MD and Sara Dyrstad, MD

Subject: Preserving the Opportunity to Moonlight

Referred to: Reference Committee

---

1 Whereas, Moonlighting has educational value in and of itself by offering graduated
2 independence during training and providing residents an opportunity to develop networks and
3 contacts in the healthcare community, assisting in their future search for employment; and
4
5 Whereas, Moonlighting has offered an additional source of income for generations of residents
6 and their families, easing the financial burden of training; and
7
8 Whereas, The average medical student in the class of 2010 had $157,944 in medical school
9 debt upon graduation and 17% of medical students had debt exceeding $200,000[1]; and
10
11 Whereas, Medical school debt and future income are implicated in residents' choice of specialty,
12 and residents with high debt loads are less likely to enter primary care fields[3,4]; and
13
14 Whereas, Medical school debt is implicated in poor quality of life and burnout among residents[2];
15 and
16
17 Whereas, The availability of a moonlighting pool allows community hospitals flexibility in
18 scheduling and access to much needed manpower enhancing patient care; and
19
20 Whereas, Some residency programs have banned external moonlighting while continuing to
21 allow internal moonlighting at compensation rates below fair-market value of those found with
22 external moonlighting positions; and
23
24 Whereas, Several instances of abuses have been raised by trainees, including situations in
25 which internal moonlighting is mandated by programs; and
26
27 Whereas, Our AMA has supported policies including both external and internal moonlighting in
28 the summation of resident duty hours, with appropriate monitoring by program directors to
29 ensure duty hour compliance and patient safety; therefore be it
30
31 RESOLVED, That our AMA discourage residency programs from allowing only internal
32 moonlighting and banning external moonlighting, and be it further
33
34 RESOLVED, That our AMA support the opportunity for residents to moonlight with appropriate
35 supervision and duty hour oversight as moonlighting eases the burden of medical school debt
36 and provides incentive for residents who may choose to enter primary care fields or academic
37 positions, and be it further
38
39 RESOLVED, That this resolution be immediately forwarded to the AMA-HOD at I-11.

Fiscal note: Less than $500

REFERENCES:

1. American Association of Medical Colleges 2010 Graduation Questionnaire.
2. West CP, Shanafelt TD, Kolars JC. Quality of life, burnout, educational debt, and medical knowledge among internal medicine residents. JAMA 2011;306:952-60.
3. Ebell MH. Future salary and US residency fill rate revisited. JAMA 2008;300:1131-2.
4. Choice of specialty: it's money that matters in the USA. JAMA 1989;262:1630.

Relevant AMA Policy

D-310.955 Resident/Fellow Duty Hours, Quality of Physician Training, and Patient Safety
8. Our AMA will urge the ACGME to include external moonlighting hours in the calculation of duty hours, as defined in the IOM report, and also to ensure increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, which may help mitigate the need for moonlighting.

H-310.927 Resident Physician Working Conditions
(10) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work. (CME Rep. 9, A-02)

E-8.088 Resident Physicians' Involvement in Patient Care
(5) Residents and fellows are obligated, as are all physicians, to monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. (See Opinion E-9.035, "Physician Health and Wellness.") Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, "moonlighting") might be potentially harmful to themselves and patients. Other activities that interfere with adequate rest during off-hours might be similarly harmful.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution 5
(I-11)

Introduced by: Luke Selby, MD, Kristina Maletz, MD, and Steve Lee, MD

Subject: Health Policy Education in Medical School and Residency

Referred to: Reference Committee

---

1 Whereas, Although most medical schools teach some health policy in their curriculum, the
2 amount of instruction varies widely[1,2]; and
3
4 Whereas, Results from the 2007 AAMC Graduate Questionnaire revealed that less than 50% of
5 medical students believed they had been appropriately educated about topics such as medical
6 economics and health care systems[3]; and
7
8 Whereas, No data exists on the prevalence of health policy education during residency, and
9
10 Whereas, Residency programs would benefit from a health policy curriculum in order to attain
11 the ACGME mandated requirement for competency in systems-based practice; and
12
13 Whereas, Recent political discussions about healthcare have shown the role physicians need to
14 play in advocating on our patient's behalf to legislators; and
15
16 Whereas, Health policy literacy affects one's ability to effectively practice medicine; and
17
18 Whereas, The practice of medicine is due to change rapidly over the next several years, a
19 change current and future physicians must be involved with; and
20
21 Whereas, Our AMA is uniquely positioned to instruct medical students and physicians on health
22 policy and has a long history of advocating for specific changes to medical and health-
23 professional education, including health; therefore be it
24
25 RESOLVED, That our AMA work with interested organizations to develop a health policy
26 curriculum for medical school and residency training that is based on a list of core topics integral
27 to the fundamental understanding of health policy (Directive to Take Action).

Fiscal note: Estimated at less than $5000 to communicate with other organizations

REFERENCES:

1. Mou D, Sarma A, Sethi R, and Merryman R., The State of Health Policy Education in U.S. Medical Schools. N Engl J Med. 2011 Mar 10;364(10):e19. Epub 2011 Feb 23
2. Patel MS, Davis MM, Lypson ML., Advancing Medical Education by Teaching Health Policy. N Engl J Med. 2011 Feb 24;364(8):695-7.
3. Patel MS, Lypson ML, Davis MM. Medical student perceptions of education in health care systems. Acad Med 2009;84:1301-1306

RELEVANT AMA POLICY:

H-440.969 Meeting Public Health Care Needs Through Health Professions Education
1) Faculties of programs of health professions education should be responsive to the expectations of the public in regard to the practice of health professions. Faculties should consider the variety of practice circumstances in which new professionals will practice. Faculties should add curriculum segments to ensure that graduates are cognizant of the services that various health care professionals and alternative delivery systems provide. **Because of the dominant role of public bodies in setting the standards for practice, courses on health policy are appropriate for health professions education. (Emphasis added)** Additionally, governing boards of programs of education for the health professions, as well as the boards of the institutions in which these programs are frequently located, should ensure that programs respond to changing societal needs. Health professions educators should be involved in the education of the public regarding health matters. Programs of health professions education should continue to provide care to patients regardless of the patient's ability to pay and they should continue to cooperate in programs designed to provide health practitioners in medically underserved areas. (2) Faculty and administrators of health professions education programs should participate in efforts to establish public policy in regard to health professions education. Educators from the health professions should collaborate with health providers and practitioners in efforts to guide the development of public policy on health care and health professions education. (BOT Rep. NN, A-87; Reaffirmed: CSA Rep. 8, A-05)

H-295.977 Socioeconomic Education for Medical Students
The AMA favors (1) continued monitoring of U.S. medical school curricula and (2) providing encouragement and assistance to medical school administrators to include or maintain material on health care economics in medical school curricula. (CME Rep. B, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-295.871 Initiative to Transform Medical Education: Strategies for Medical Education Reform
Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role. (CME Rep. 13, A-07)

H-460.971 Support for Training of Biomedical Scientists and Health Care Researchers
Our AMA: (1) continues its strong support for the Medical Scientists Training Program's stated mission goals; (2) supports taking immediate steps to enhance the continuation and adequate funding for stipends in federal research training programs in the biomedical sciences and health care research, including training of combined MD and PhD, biomedical PhD, and post-doctoral (post MD and post PhD) research trainees; (3) supports monitoring federal funding levels in this area and being prepared to provide testimony in support of these and other programs to enhance the training of biomedical scientists and health care research; (4) supports a comprehensive strategy to increase the number of physician-scientists by: (a) emphasizing the importance of biomedical research for the health of our population; (b) supporting the need for career opportunities in biomedical research early during medical school and in residency training; (c) advocating National Institutes of Health support for the career development of physician-scientists; and (d) encouraging academic medical institutions to develop faculty paths supportive of successful careers in medical research; and (5) supports strategies for federal government-sponsored programs, including reduction of education-acquired debt, to encourage training of physician-scientists for biomedical research. (Res. 93, I-88; Reaffirmed: Sunset Report, I-98; Amended: Sub. Res. 302, I-99; Appended: Res. 515 and Reaffirmation A-00; Reaffirmed: CME Rep. 14, A-09)

H-295.894 Medical Education on Sleep and Sleep Disorders
Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education. (Res. 310 , I-98; Reaffirmed: CME Rep. 2, A-08)

H-295.922 Establishing Essential Requirements for Medical Education in Substance Abuse
AMA policy states that alcohol and other drug abuse education needs to be an integral part of medical education; and that the AMA supports the development of programs to train medical students in the identification, treatment, and prevention of alcoholism and other chemical dependencies. Our AMA: (1) asks all residency review committees to review their training requirements in the treatment and management of substance abuse and addiction and to make recommendations for strengthening this provision as needed; and (2) encourages the development of specialty-specific needs assessment to determine whether targeted educational activities in substance abuse would be useful in their overall program of continuing medical education (Res. 303, I-94; Reaffirmed and Appended: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution 6
(I-11)

Introduced by: Mississippi RFS Delegation

Subject: Making GME Financing and Reform a Priority for AMA

Referred to: Reference Committee

---

1 Whereas, Many organizations, including our American Medical Association (AMA), have
2 released data and studies indicating that the United States will need increasing numbers of
3 physicians in most specialties in the near future to treat its increasingly aging population and to
4 provide an appropriately sized and balanced medical workforce; and
5
6 Whereas, U.S. medical schools have expanded class sizes and new medical schools have been
7 created to address this coming physician workforce crisis; and,
8
9 Whereas, The solution for increasing physician numbers and balance in the United States
10 involves not only increasing medical student class sizes and numbers, but also increasing both
11 the number of graduate medical education (GME) residencies and number of positions in
12 established residencies in the United States; and
13
14 Whereas, Despite the urgent need to expand GME, especially for primary care residency
15 positions, the financing mechanisms for GME currently block the necessary reform and
16 expansion needed to produce a physician workforce that is appropriately sized, balanced, and
17 skilled as is described in Council on Graduate Medical Education (COGME) Report released
18 December 2010; and
19
20 Whereas, Medicare is the single largest contributor to GME while other health insurers are not
21 required to contribute to GME; and
22
23 Whereas, While our AMA reaffirmed several policies during its 2011 Annual Meeting, and while
24 the AMA Center for Transforming Medical Education and the AMA Advocacy Resource Center
25 have recently released "*Critical condition: The call to increase graduate medical education*
26 *funding*" which identified four main objectives to collect data, add resources for GME funding,
27 develop innovative methods for distribution of GME funds, and create flexibility in GME training
28 methods to meet future patient needs, this issue is of such importance that new efforts should
29 be adopted; and
30
31 Whereas, the complexity of these problems warrants a broad and far-reaching study to provide
32 a thorough analysis of the issues and also provide guidelines for enacting necessary changes;
33 and
34
35 Whereas, our AMA's authorization and endorsement of the Flexner Report in the early twentieth
36 century in response to shortcomings and crisis in medical education provided historic leadership
37 for reforms on a national level; therefore be it
38

1 RESOLVED, That our AMA recognize that funding for and distribution of positions for graduate
2 medical education (GME) are in crisis in the United States and that meaningful and
3 comprehensive reform is urgently needed; and be it further
4
5 RESOLVED, That our AMA immediately work with Congress to expand medical residencies in a
6 balanced fashion based on expected specialty needs throughout our nation to produce a
7 geographically distributed and appropriately sized physician workforce; and to make increasing
8 support and funding for GME programs and residencies a top priority of the AMA in its national
9 political agenda; (Directive to take action) and be it further
10
11 RESOLVED, That our AMA conduct a study of the current status of the GME system of the
12 United States of the depth and scope of the Flexner Report's analysis of medical school
13 education, with an emphasis on the problems related to the funding and distribution of residency
14 positions; (Directive to take action) and be it further
15
16 RESOLVED, That our AMA furnish a study of the current status of the GME system as a
17 guideline for funding reforms and for future expansion of residency programs to help correct
18 specialty shortages in physician workforce; and be it further
19
20 RESOLVED, That our AMA report back to the HOD on the progress of this study no later than
21 Interim 2012.

Fiscal note: $750,000 to complete study

Relevant AMA Policy:

D-305.967 The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the contribution by all payers for health care, (including the federal government, the states and private payers), to funding both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and

serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME. (Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11)

D-305.992 Accounting for GME Funding
Our AMA will encourage: (1) department chairs and residency program directors to learn effective use of the information that is currently available on Medicare funding accounting of GME at the level of individual hospitals to assure appropriate support for their training programs, and publicize sources for this information, including placing links on our AMA web site; and (2) hospital administrators to share with residency program directors and department chairs, accounting and budgeting information on the disbursement of Medicare education funding within the hospital to ensure the appropriate use of those funds for Graduate Medical Education. (Sub. Res. 302, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation A-11)

D-305.990 Impact of Health System Changes on Medical Education
Our AMA will continue to monitor the financial status of academic medical centers and the availability of faculty and patients to support the clinical education of medical students and resident physicians. This should both include collecting information and synthesizing information from other sources on these issues. (CME Rep. 4, A-01; Reaffirmed: CME Rep. 2, A-11)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution 7
(I-11)

Introduced by: Minnesota Medical Association Resident and Fellow Section

Subject: Elimination of the Secured Examination Requirement for Maintenance of Certification

Referred to: Reference Committee

---

1 Whereas, There is lack of compelling evidence suggesting that requiring the sitting for a secure
2 examination as part of the maintenance of certification (MOC) program of the American Board
3 of Medical Specialties (ABMS) results in improved physician performance and patient
4 outcomes; and
5
6 Whereas, The components of MOC, with the exception of the secure examination, are focused
7 on self-directed and experientially-oriented learning and quality improvement and the
8 relationship between physician performance, patient outcomes, and processes and systems of
9 care; and
10
11 Whereas, Practicing physicians rely on more than retained knowledge in the diagnosis and
12 treatment of patients, including consultations with colleagues, written materials, and information
13 technology-based resources, none of which are allowed during a secured examination; and
14
15 Whereas, Adult learners do not perform well on secure examinations and a significant minority
16 experience severe stress with this type of test setting; and
17
18 Whereas, Physicians participating in the ABMS MOC can pass the other three components of
19 MOC, but may fail the secure exam as currently structured by the ABMS, resulting in non-
20 certification; and
21
22 Whereas, The Federation of State Medical Boards does not recommend a secure examination
23 as part of their maintenance of licensure guidelines; and
24
25 Whereas, Existing AMA policies H-275.923, D-275.969, D-275.977, and D-270.989 call for
26 continued monitoring of ABMS and MOC requirements but none of them call for the
27 discontinuation of the secure examination requirements; therefore be it
28
29 RESOLVED, That our AMA work with the American Board of Medical Specialties to remove the
30 requirement for a secure examination as part of their Maintenance of Certification program.
31 (Directive to Take Action)

Fiscal note: Estimated at less than $5000 to communicate with ABMS.

REVEVANT AMA POLICY

D-275.969 Specialty Board Certification and Recertification
(1) Our AMA will continue to monitor the progress by the ABMS and its member boards on implementation of Maintenance of Certification (MOC) and encourage ABMS to report its research

findings on the issues surrounding certification, recertification and MOC on a periodic basis; (2) An update report will be prepared for the AMA House of Delegates no later than 2010; (3) AMA will encourage dialogue between the ABMS and its respective specialty societies to work on development, implementation, and monitoring of MOC that meets the needs of practicing physicians and improves patient care; (4) AMA will exercise its full influence to protect physicians from undue burden and expense in the Maintenance of Certification process. (CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09)

D-270.989 Improvements to the Maintenance of Certification Process
By September 15, 2008, our AMA Board of Trustees will write a letter to the American Board of Medical Specialties (ABMS) asking that it work with its 24 member boards to: a. coordinate with each other, the ABMS, specialty societies and the AMA to ensure that the demands of Maintenance of Certification (MOC) are reasonable; b. educate physicians and increase their understanding of the MOC process and its requirements; c. solicit physician input and feedback regarding MOC implementation; d. make transparent all recertification-related costs; e. work to minimize the disruption of physician practice due to MOC requirements; and f. ensure that the number of MOC-related testing dates and the locations of testing sites are ample enough to minimize the burden on physician practices and their time away from clinical care. (Res. 323, A-08; Reaffirmed: CME Rep. 16, A-09)

H-275.923 Maintenance of Certification / Maintenance of Licensure
Our AMA will: (1) Continue to work with the Federation of State Medical Boards (FSMB) to establish and assess maintenance of licensure (MOL) principles with the AMA to assess the impact of MOC and MOL on the practicing physician and the FSMB to study the impact on licensing boards. (2) Recommend that the American Board of Medical Specialties (ABMS) not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety. (3) Encourage rigorous evaluation of the impact on physicians of future proposed changes to the MOC and MOL processes including cost, staffing, and time. (4) Review all AMA policies regarding medical licensure; determine if each policy should be reaffirmed, expanded, consolidated or is no longer relevant; and in collaboration with other stakeholders, update the policies with the view of developing AMA Principles of Maintenance of Licensure in a report to the HOD at the 2010 Annual Meeting. (5) Urge the National Alliance for Physician Competence (NAPC) to include a broader range of practicing physicians and additional stakeholders to participate in discussions of definitions and assessments of physician competence. (6) Continue to participate in the NAPC forums. (7) Encourage members of our House of Delegates to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
(8) Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major CME credit systems that comprise the foundation for post graduate medical education in the US, including the Performance Improvement CME (PICME) format; and continue to develop relationships and agreements that may lead to standards, accepted by all US licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME.
(9) Collaborate with the American Osteopathic Association and its eighteen specialty boards in implementation of the recommendations in CME Report 16-A-09, Maintenance of Certification / Maintenance of Licensure. (10) Continue to support the AMA Principles of Maintenance of Certification (MOC). (11) Monitor MOL as being led by the Federation of State Medical Boards (FSMB), and work with FSMB and other stakeholders to develop a coherent set of principles for MOL. (CME Rep. 16, A-09; Appended: CME Rep. 3, A-10; Reaffirmed: CME Rep. 3, A-10)

D-275.977 Update on the American Board of Medical Specialties Program on Maintenance of Certification (MOC)
Our AMA will: (1) continue to monitor the progress of Maintenance of Certification (MOC) and its ultimate impact on the practice community; (2) encourage the Physician Consortium for Performance Improvement, the American Board of Medical Specialties, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of MOC; and (3) encourage the ABMS Maintenance of Certification Task Force to develop and adopt recommendations for re-entry into clinical practice and entry into Step IV of MOC for diplomates not involved in direct patient care. (CME Rep. 9, A-05; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09).

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 8
(I-11)

Introduced by: The Maryland State Medical Society (MedChi) and The American Society of Interventional Pain Physicians (ASIPP)

Subject: Board Certification of Physician and Surgeons

Referred to: Reference Committee

---

1 Whereas, A physician (MD or DO), goes through four years of medical school training, which
2 encompasses comprehensive education in a majority of medical disciplines; and
3
4 Whereas, Most physician and surgical residencies and fellowships encompass a certain amount
5 of education which is closely related and equivalent to other overlapping medical and surgical
6 subspecialties and disciplines; and
7
8 Whereas, Competence in the performance of medicine and surgery is often more reliant on the
9 training, aptitude, interest and experience of each physician rather than strictly on their primary
10 specialty training; and
11
12 Whereas, There is much discord and territorial struggling by physicians and surgeon
13 subspecialties against other physician and surgeon subspecialties; and
14
15 Whereas, A number of physicians are more than experienced and capable to be trained in
16 providing treatment and services that are outside of their primary specialty; and
17
18 Whereas, The treatment of patients by-and-large necessitates a requirement for the board
19 certification of physicians and surgeons to ensure their competence and the validity of their
20 specialty or subspecialty training; and
21
22 Whereas, There exist many biases which often drive the exclusion to fellowship training
23 between primary specialties and subspecialties in ignorance of the knowledge, interest,
24 experience, aptitude, and academic records of fellowship applicants; and
25
26 Whereas, Many of these feuds are driven by monetary compensation and not purely by patient
27 safety; therefore be it
28
29 RESOLVED, That our AMA work toward removing obstacles and barriers from physicians and
30 surgeons from participating in fellowships outside their primary disciplines; and be it further
31
32 RESOLVED, That our AMA work toward the creation of further sub-specialized subspecialty
33 boards within specialties and sub-specialties to encompass training that can be, and is,
34 common to many disciplines, but the performance of which is not in the purview of the primary
35 specialty and sub-specialty boards of certain physician providers which commonly practice
36 these disciplines; and be it further
37
38 RESOLVED, That our AMA work toward increasing the eligibility of current and future
39 specialists and subspecialists to competence testing by subspecialty boards of other disciplines

1 if their training is largely similar, by increasing their eligibility for sitting for subspecialty board
2 certification exams with the interest of increasing the quality and safety of board certified and
3 practicing physician subspecialists; and be it further
4
5 RESOLVED, That our AMA actively work toward creating a workforce of physician and
6 surgeons that are board certified by specialty and/or subspecialty boards if they are to practice
7 any particular medical or surgical discipline to ensure a minimum standard of scientific aptitude
8 for practicing physicians; and be it further
9
10 RESOLVED, That our AMA reaffirm its current policy of not requiring board certification for the
11 practice of any procedure or discipline of medicine or surgery which is considered in the purview
12 of the primary specialty, or subspecialty, in which the physician or surgeon has trained.

Fiscal Note: $10,500

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution 9
(I-11)

Introduced by: Minnesota RFS Delegation

Subject: Transparency in Consumer Communications

Referred to: Reference Committee

---

1 Whereas, Patients are likely to assume that physicians who advertise their board certification
2 have been subjected to a rigorous peer review of their education, training, and experience to
3 perform advertised services; and
4
5 Whereas, Our AMA Scope of Practice Partnership has done an excellent job of advancing its
6 truth in advertising campaign, including the introduction or adoption of its model truth in
7 advertising legislation in several states; and
8
9 Whereas, Our AMA Scope of Practice Partnership's model bill includes disclosure of licensure
10 or certification via nametags, advertisements, and other public communications, but does not
11 include language regarding transparency of board certification; and
12
13 Whereas, The federal truth in advertising legislation, HR 451, similarly does not include
14 language regarding transparency of board certification; and
15
16 Whereas, Transparency of board certification provides important information to patients but
17 does not restrict a physician's ability to perform any procedure for which he or she is licensed;
18 and
19
20 Whereas, Patients are misled as to the specialized training of their treating physician when,
21 either expressly or by implication, physicians advertise themselves as being "Board Certified" in
22 a specialization other than that in which they are certified; and
23
24 Whereas, Patients are misled when physicians advertise themselves as being "Board Certified"
25 by a board that is not an American Board of Medical Specialties member board or American
26 Osteopathic Association certifying board, a board with equivalent requirements approved by that
27 person's medical licensing authority, or a board requiring a postgraduate training program that
28 provides complete training in the person's specialty or subspecialty approved by the
29 Accreditation Council for Graduate Medical Education; and
30
31 Whereas , Some of these non-recognized Boards may require as little training as a weekend
32 course; and
33
34 Whereas, Laws or regulations requiring physicians to be clear in specifying in which boards they
35 are advertising exist in the following states: California, Colorado, Louisiana, Maryland, and
36 Mississippi; and
37
38 Whereas, Requiring transparency in board certification claims is in compliance with Section 5 of
39 the Federal Trade Commission Act and ethical opinion 5.02 of the Council of Ethical and
40 Judicial Affairs; therefore be it

RESOLVED, That our AMA be directed to add the following language to their model truth in advertising legislation (Directive to Take Action):

An advertisement for health care services that includes a licensed medical doctor or doctor of osteopathic medicine's name shall not include a statement that he or she is "board certified" unless that board is: an American Board of Medical Specialties member board or American Osteopathic Association certifying board, a board with equivalent requirements approved by that person's medical licensing authority, or a board requiring a postgraduate training program that provides complete training in the person's specialty or subspecialty approved by the Accreditation Council for Graduate Medical Education and shall disclose the name of the board or association in which the person is certified.

; and be it further

RESOLVED, That our AMA request Federal Trade Commission (FTC) investigation of whether advertising which refers to certain "board certifications" is false and misleading under the FTCA and FTC regulations when it refers to boards that are so-called "knock-off boards," (i.e. those which have weak certification standards and give the false appearance of certification by a competent certifying body); and be it further

RESOLVED, That AMA federal government relations staff investigate the feasibility of adding the following language to the federal truth in advertising bill, HR 451 (Directive to Take Action):

An advertisement for health care services that includes a licensed medical doctor or doctor of osteopathic medicine's name shall not include a statement that he or she is "board certified" unless that board is: an American Board of Medical Specialties member board or American Osteopathic Association certifying board, a board with equivalent requirements approved by that person's medical licensing authority, or a board requiring a postgraduate training program that provides complete training in the person's specialty or subspecialty approved by the Accreditation Council for Graduate Medical Education and shall disclose the name of the board or association in which the person is certified.

Fiscal note: No significant fiscal impact

RELEVANT AMA POLICY

H-405.967 Truth in Corporate Advertising: Using Professional Degrees in Advertising Listings
The AMA opposes US West Yellow Pages or any other corporation which misrepresents physicians by failing to list their professional degrees in the corporation's advertising directory. (Sub. Res. 4, I-95; Reaffirmed with change in title: CLRPD Rep. 1, A-05; Reaffirmation I-09)

H-175.992 Deceptive Health Care Advertising
Our AMA (1) encourages and assists all physicians and medical societies to monitor and report to the appropriate state and federal agencies any health care advertising for which there is a reasonable, good-faith basis for believing that said advertising is false and/or deceptive in a material fact, together with the basis for such belief; and (2) encourages medical societies to keep the Association advised as to their actions relating to medical advertising. (Sub. Res. 102, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 13, I-01)

E-5.02 Advertising and Publicity
There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herself as a physician

through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct mail, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive. Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive, high-pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity, regardless of format or content, is true and not materially misleading. The communication may include (1) the educational background of the physician, (2) the basis on which fees are determined (including charges for specific services), (3) available credit or other methods of payment, and (4) any other nondeceptive information. Nothing in this opinion is intended to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention. For example, testimonials of patients as to the physician’s skill or the quality of the physician’s professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant’s condition generally receive. Objective claims regarding experience, competence, and the quality of physicians and the services they provide may be made only if they are factually supportable. Similarly, generalized statements of satisfaction with a physician’s services may be made if they are representative of the experiences of that physician’s patients. Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients. Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. Inclusion of the physician’s name in advertising may help to assure that these guidelines are being met. (II) Issued prior to April 1977; Updated June 1996.

H-405.985 Truthful Specialty Information
Our AMA: (1) reaffirms its policy that: (a) individual character, training, competence, experience and judgment be the criteria for granting privileges in hospitals; (b) physicians representing several specialties can and should be permitted to perform the same procedures if they meet these criteria; (c) a physician who acquires new skills as a result of additional education or training should be given individual evaluation and the same consideration as a new physician applying for privileges; and (2) believes that advertising by physicians should comply with ethical opinion 5.02 of the Council of Ethical and Judicial Affairs. (Sub. Res. 11, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 10
(I-11)

Introduced by: American Society of Interventional Pain Physicians; Illinois State Medical Society; Iowa Medical Society; Maryland State Medical Society; Minnesota Medical Association; Missouri State Medical Association; Nebraska Medical Association; North Dakota Medical Association; South Dakota Medical Association; Wisconsin Medical Society

Subject: Reimbursement Data for Non-physician Health Care Providers from the Center of Medicare & Medicaid Services.

Referred to: Reference Committee

---

1 Whereas, There is a crisis regarding health care expenditure in the United States, and there is a
2 pressing need for timely identification of areas of inappropriate costs; and
3
4 Whereas, There has been independent billing by non-physician health care providers for
5 services rendered since the Balanced Budget Act of 1997; and
6
7 Whereas, There is unregulated and independent practice of non-physician health care providers
8 in numerous specialties in many states; and
9
10 Whereas, There is practice of non-physician health care providers in specialties and
11 subspecialties that they have no training whatsoever, solely for the purpose of monetary gain;
12 and
13
14 Whereas, There now exist numerous online and other questionable non-physician educational
15 advancement tracks and degrees in multiple specialties and/or disciplines; and
16
17 Whereas, Ordering diagnostic tests, prescribing medications, devices, and therapies,
18 performance of procedures, and completion and referrals of consultations and/or follow-up visits
19 that are not necessary, not only places patients at risk, but also increases the overall health
20 expenditure burden; and
21
22 Whereas, Data regarding reimbursement to non-physician health care providers for services
23 rendered by CPT code from the Center for Medicare & Medicaid Services is unpublished and/or
24 unavailable to the AMA and its constituent physician and surgeon, state and specialty societies;
25 and
26
27 Whereas, Reimbursement to physicians and surgeons for services rendered by specialty,
28 subspecialty, CPT code and year is published and available from the Center for Medicare &
29 Medicaid Services; therefore be it
30
31 RESOLVED, That our AMA work with the Center for Medicare & Medicaid Services to institute a
32 rule that would provide comprehensive de-identified aggregated and not individual specific data
33 on total billed and total collected reimbursement by non-physician health care providers, broken
34 down by provider type, provider subspecialty, CPT code, and if applicable, identified by the

1 appropriate physician modifiers for the number of non-physician providers utilized, if multiple,
2 from physicians, if indirect billing is utilized, from the year 1997 to present; and be it further
3
4 RESOLVED, That the AMA work to institute a rule that this data should be published and made
5 openly available by the Center for Medicare & Medicaid Services on a semi-annual basis for the
6 membership of both the AMA and its constituent physician and surgeon, state and specialty
7 societies and organizations, and be it further
8
9 RESOLVED, That due to the timely nature of these issues, specifically with regards to the
10 creation of budget cuts by a bipartisan congressional panel in the coming months; this
11 resolution should be forwarded immediately to our AMA House of Delegates at I-11.

Fiscal Note: TBD

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: C
(I-11)

Introduced by: RFS Governing Council

Subject: AMA-RFS Sunset Mechanism: 2001 Actions to Reaffirm
Action Report

Referred to: Reference Committee

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 reaffirmation. A complete description of these actions is included

<u>2001 AMA-RFS Actions Recommended for Reaffirmation:</u>

30.998R Alcohol and Youth
130.994R Emergency Preparedness
295.996R Endorsement for Appropriate Medical Student Training Conditions
305.897R Graduate Medical Education Funding
305.898R GME Financing
305.986R Student Loan Interest Deduction
305.987R Deferment Period for U.S. Medical School Graduates' Subsidized Federal Stafford Loans
310.580R Resident/Fellow Work and Learning Environment
310.581R Residency Housestaff Leave Requirements
370.998R National Marrow Donor Program: Cord Blood Donation
405.987R Part-Time Malpractice Insurance
440.982R Mercury Exposure and the Reduction of Fish Consumption
440.983R Impact of Biodiversity Loss on Human Health
530.996R AMA Annual Meeting Schedule
630.988R AMA-RFS Strategic Plan: Vision, Mission, and Objectives
640.998R Communication between the AMA-RFS Governing Council and State Society Resident and Fellow Sections
640.999R Neutrality of Governing Council During Elections
655.996R Expanding the Definition of a Resident

30.998R Alcohol and Youth: Asked that (1) the AMA encourage state medical societies to work with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol and (2) that the AMA work with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents. (RFS Substitute Resolution 9, A-01) (AMA-HOD Resolution 415, I-01)

130.994R Emergency Preparedness: Asked that 1) the AMA commend the physicians and other volunteers who demonstrated the true spirit of medicine during the September 11, 2001 terrorist attacks, (2) that the RFS support the AMA's development and maintenance of a physicians volunteer database, and (3) that the RFS support the AMA's effort to educate physicians on natural and man-made disaster related topics. (RFS Substitute Resolution 1, I-01)

160.989R Cost-Effectiveness of Medicaid Eligibility Criteria for the Chronically Ill: Asked that the AMA examine the appropriateness and cost-effectiveness of "the spend down option" to meet Medicaid eligibility criteria in the broader context of Medicaid reform with a report back at I-02. (RFS Substitute Resolution 6, A-01) (AMA-HOD Resolution 102, I-01)

295.996R Endorsement for Appropriate Medical Student Training Conditions: Asked that the RFS endorse resolutions and policies that seek the development of professional guidelines addressing the issue of appropriate medical student training hours and training conditions during clinical clerkship. (RFS Resolution 3, I-01)

305.897R Graduate Medical Education Funding: Asked that the AMA-RFS (1) continue to monitor and report on the issue of Medicare graduate medical education funding; and (2) through its communications vehicles, publicize and educate resident physicians on the issue of Medicare GME funding. (RFS Report E, I-91) (Reaffirmed: RFS Report C, I-01) [See also: AMA Policy H-305.956]

305.898R GME Financing: Asked that the AMA-RFS continue its strong opposition to reductions of Medicare funding for graduate medical education; (RFS Substitute Resolution 12, A-91) (Reaffirmed: Report C, I-01)[See also: AMA Policy H-305.956]

305.986R Student Loan Interest Deduction: Asked that (1) the RFS work to continue active lobbying by the AMA on student loan tax relief, (2) that the RFS reaffirm RFS and AMA policies that support expanding the tax deductibility of student loan interest, and (3) that the RFS thank the American Medical Political Action Committee for its support for resident and medical student lobbying efforts on student loan relief and other issues. (RFS Substitute Resolution 7, A-01)

305.987R Deferment Period for U.S. Medical School Graduates' Subsidized Federal Stafford Loans: Asked (1) that the RFS continue to support the ongoing efforts of the AMA to expand economic hardship deferment provisions for residents for the duration of their postgraduate training; and (2) that the AMA develop legislation to expand economic hardship deferment provisions for resident physicians. (RFS Substitute Resolution 1, A-01)

310.580R Resident/Fellow Work and Learning Environment: Asked that (1) the AMA may draft original, modify existing, or oppose legislation and pursue any regulatory or administrative strategies when dealing with resident work hours and conditions, (2) that the AMA work with organizations such as the Accreditation Council for Graduate Medical Education (ACGME), the Joint Commission, and other appropriate organizations, toward finding

solutions to the problem of work hours and conditions which would strengthen current work hours enforcement mechanisms, (3) that the AMA encourage the Agency for Healthcare Research and Quality (AHRQ) to examine the link between resident work hours and patient safety and to explore possible solutions to the problem of work hours and conditions, and (4) that the RFS Governing Council report back the RFS Assembly at A-02. (RFS Report F, I-01) [See Also: AMA Policy H-310.928]

310.581R Residency Housestaff Leave Requirements: Asked that the RFS encourage the various specialty boards to adopt the RFS model for residency leave requirements and that this information be provided by residency programs to residents at the time of application for training. (RFS Report E, I-01)

405.987R Part-Time Malpractice Insurance: Asked that the RFS endorse policies that support investigation of the validity of reduced premiums for part-time physicians. (RFS Substitute Resolution 4, I-01)

440.982R Mercury Exposure and the Reduction of Fish Consumption: Asked that the AMA support the FDA's efforts to educate consumers about mercury exposure from fish consumption. (RFS Substitute Resolution 5, A-01)

440.983R Impact of Biodiversity Loss on Human Health: Asked that the AMA support legislation that protects biodiversity for the purpose of benefiting human health, especially in terms of the development of drugs and biologicals to treat diseases. (RFS Substitute Resolution 4, A-01)

530.996R AMA Annual Meeting Schedule: Asked that the AMA change its House of Delegates Annual Meetings so that they take place prior to the last two weeks of June. (RFS Resolution 16, A-91) (Reaffirmed: RFS Report C, I-01)

630.988R AMA-RFS Strategic Plan: Vision, Mission, and Objectives: Asked that the RFS utilize the vision, mission and objectives set forth by the AMA-RFS Committee on Long Range Planning as a foundation for further planning. (RFS Report E, A-01)

640.998R Communication between the AMA-RFS Governing Council and State Society Resident and Fellow Sections: Asked that the AMA-RFS (1) establish a list of state and specialty society resident physicians section chairpersons; and (2) publish a list of state and specialty society resident physicians section chairpersons in the Annual and Interim Assembly meeting handbooks and proceedings. Also asked that the AMA-RFS Governing Council attempt to contact each state and specialty society resident physicians section chairperson prior to each AMA-RFS Assembly meeting. (RFS Substitute Resolution 7, I-91) (Reaffirmed: RFS Report C, I-01)

640.999R Neutrality of Governing Council During Elections: Asked that the AMA-RFS Governing Council members maintain a neutral status in elections by: (1) Not wearing campaign materials, except their own. (2) Not acting as campaign manager for any candidate. (3) Not endorsing candidates from the podium. (4) Not endorsing candidates as a council. (5) Not endorsing candidates through the use of one's Governing Council title. (6) Using discretion with respect to their personal endorsements. (RFS Substitute Resolution 24, I-91) (Reaffirmed: RFS Report C, I-01)

655.996R Expanding the Definition of a Resident: Asked that the RFS Governing Council create an internal mechanism to decide the membership status of physicians in the following situations: residents who have interrupted their postgraduate training and physicians who

1 have completed residency training with the intent to return to postgraduate training within
2 one year. (RFS Report G, I-01)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: D
(I-11)

Introduced by: RFS Governing Council

Subject: AMA-RFS Sunset Mechanism: 2001 Actions to Rescind Action Report

Referred to: Reference Committee

---

1 At the 1985 Interim Meeting, the American Medical Association-Resident and Fellow Section (AMA-
2 RFS) Assembly adopted Report H, "Sunset of AMA-RFS Policy." Report H established a mechanism to
3 systematically review AMA-RFS actions ten years after their adoption. The process specifies that an
4 informational report be prepared for the Annual Meeting, with final recommendations considered at the
5 Interim Meeting.
6
7 The sunset mechanism for the AMA-RFS actions was established to identify and rescind outmoded,
8 irrelevant, duplicative, or inconsistent actions. This report contains a list of the actions adopted by the
9 AMA-RFS Assembly that are recommended for rescission. A complete description of these actions is
10 included.
11
12 **2001 AMA-RFS Actions Recommended for Rescission:**
13
14
15 **310.582R** Effect of Nursing Shortage on Medical Education
16 **310.583R** Resident and Fellow Work Hours Reform 2001
17 **440.981R** Addressing Antibiotic Resistance
18
19

1 **Appendix I: Statement of AMA-RFS Policy**
2
3
4 **310.582R** Effect of Nursing Shortage on Medical Education: Asked that the AMA study and report back
5 the effects of the nursing shortage on the working environment of physicians-in-training. (RFS
6 Substitute Late Resolution 1, I-01) [AMA-HOD Resolution 309, I-01]
7
8 **310.583R** Resident and Fellow Work Hours Reform 2001: Asked that 1) the RFS continue to make the
9 improvement of hospital working conditions, including resident/fellow work hours, a top
10 priority and report back at I-01 regarding the section's progress on this issue, (2) that the RFS
11 Governing Council work directly with other interested organizations using forums, workshops,
12 and other methods to address the issue of hospital working conditions and resident/fellow hours,
13 (3) that the RFS ask the AMA to have the Council on Medical Education evaluate the scope of
14 work hours violations by residency and fellowship programs and assess the ACGME's progress
15 in curtailing these violations with a report at I-01, (4) that the RFS ask the AMA to have the
16 Council on Scientific Affairs work with other appropriate organizations to study the effect of
17 resident/fellow sleep deprivation and fatigue on medical decision making, performance, and
18 medical errors, (5) that the RFS ask the AMA to have the Council on Legislation explore
19 legislative strategies to enforce ACGME resident/fellow work hour standards and study the
20 potential impact of state/federal legislation on work hours and teaching institutions with report
21 back at I-01, (6) that the RFS ask the AMA to have the Council on Medical Service study the
22 feasibility of enforcement of resident/fellow work hour standards by state/federal regulatory
23 agencies, and (7) that the AMA Board of Trustees review recent activities by the AMA and
24 other organizations related to resident and fellow working conditions reform and report back at
25 1-01. (RFS Report F, A-01)
26
27 **440.981R** Addressing Antibiotic Resistance: Asked that the RFS support the recommendations in AMA
28 Council on Scientific Affairs Report 3 (A-00), Combating Antibiotic resistance Via Physician
29 Action and Education: AMA Activities. (RFS Substitute Resolution 10, A-01)
30
31

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: E
(I-11)

Introduced by: Resident and Fellow Section Governing Council

Subject: Sectional Delegate Election Procedures

Referred to: Reference Committee

I. Introduction

Changes to the RFS Internal Operating Procedures (IOPs) were adopted by the RFS Assembly at the 2011 Annual Meeting (Report H, A-11) to clarify the sectional delegate election process. Based on feedback from the AMA Council on Constitution and Bylaws, the RFS Governing Council suggests that the runoff election process that is outlined in the IOP be further clarified.

II. Recommendations

1. The AMA-RFS Governing Council recommends that the AMA-RFS Internal Operating Procedure (IOP) be amended by insertion and deletion and that the remainder of the report be filed.

> 5. Method of Election. The voting system to be used in the RFS Sectional Delegate and Alternate Delegate elections will be an approval-based, plurality-at-large voting system.
>
> a. Voting Periods. The voting period for Sectional Delegates shall occur at the Interim Meeting at a time scheduled by the Speaker.
>
> 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 must vote for exactly as many candidates as there are open 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.
>
> 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

This document does not represent official policy of the American Medical Association (AMA). Refer to AMA PolicyFinder at www.ama-assn.org/go/policyfinder for official policy of the Association."

process will continue throughout the counting of ballots to ensure that there is only one RFS Sectional Delegate per endorsing state and specialty society.

iii. Unfilled Seats/Runoff Elections. If there are unfilled Sectional Delegate seats after the election, a runoff election will be held between the remaining candidates receiving the most votes with the exact number of candidates participating in the runoff to be determined by the formula 2n+1, where n equals the number of seats up for election. ~~the Governing Council based upon the results of the initial balloting.~~ During the run-off election, the candidate(s) who receive(s) the highest number of votes, with a majority of legal votes cast, shall be elected. This process will continue until all Sectional Delegate and Alternate Delegate seats are filled. If unfilled seats remain after elections are completed, one additional Sectional Delegate and Alternate Delegate per endorsing state/specialty society will be allowed in a subsequent balloting period. This process will continue through as many counting rounds as needed until all Sectional Delegate and Alternate Delegate seats are filled.

Fiscal note: No significant fiscal impact.

This document does not represent official policy of the American Medical Association (AMA). Refer to AMA PolicyFinder at www.ama-assn.org/go/policyfinder for official policy of the Association.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: F
(I-11)

Introduced by: Legislative Advocacy Committee

Subject: Reimbursement for Phone Consultations

Referred to: Reference Committee

I. Introduction

A resolution addressing reimbursement for physician phone consultations was brought forth to the American Medical Association Resident and Fellow Section (AMA-RFS) during the Interim 2010 meeting. The resolution called for the AMA to "work with all relevant parties to create a method for physicians to bill for phone consultations." At the time, the resolution was referred to Committee for report back to the RFS House of Delegates.

The Legislative Advocacy Committee has been charged with further researching this topic and has compiled our findings into this report.

II. Background

A phone consultation is a type of informal consultation whereby a physician obtains information or advice from another physician (consultant) over the telephone to assist in patient management. Oftentimes the consultant is unfamiliar with and does not examine the patient; rather, the recommendations provided by the consultant are formed solely on the basis of the information supplied by the consulting physician (Kuo et al 1998). The term "curbside consult" is sometimes used interchangeably with phone consultations in the medical literature. Phone consultations are typically initiated by primary care physicians to subspecialists, but often primary care physicians are also "curbsided" for medical opinions regarding patient care.

Despite the fact that time, expense, liability, and an advanced level of assessment and judgment are required to conduct phone consultations, most health care plans do not reimburse physicians for providing telephone care (Melzer and Poole 2002). It is unlikely that phone consultations will disappear from daily medical practice, however, due to their perceived value particularly by primary care physicians (Wegner et al 2008). Efforts are being undertaken to create a reimbursement mechanism for these valuable patient-related communications.

III. Discussion

There are several advantages and disadvantages to creating CPT codes for telecommunication between physicians. Medicine is evolving into a technologically advanced field with increasing means of physician-to-physician and physician-to-patient communication. Although physicians and patients generally agree that the time and efforts physicians invest in patient care should be reimbursed, questions arise over what should and should not be considered eligible for CPT coding and billing.

Advocates for physician reimbursement of phone consultations cite several potential advantages of these services, which can be broadly categorized into patient, physician, and fiscal benefits.

- Patient benefits
  - Improved quality of care for patients who otherwise may not have access to subspecialist consultants, such as the rural and geriatric populations (Wegner et al 2008; Rosenfeld et al 2000).
  - Avoidance of additional office visits for subspecialist care (Wegner et al 2008).
  - Quicker management of complex medical issues when compared to scheduling patients for in-office visits that can often be delayed for months, particularly in highly specialized fields (Krupinski et al 2002).
  - Bridging of care for patients in areas where wait times to see subspecialists can be months (Marcin et al 2004).
  - Potentially increased patient satisfaction and improvement in the physician-patient relationship if the patient's medical problem can be managed by the primary care provider (PCP) in consultation with specialists over the phone (Marcin et al 2004).
- Physician benefits
  - Phone consultations may lead to formal consultations, which can help establish and maintain a physician's referral base (Kuo, Gifford and Stein 1998).
  - Informal consultations by telephone may be used as a means for those physicians obtaining consultations to keep current with medical information (in addition to CME courses, journal articles, and textbooks) (Kuo, Gifford and Stein 1998).
  - Improves physician-to-physician communication and patient co-management, especially in subspecialist access-restrained areas (Wegner et al 2008; Marcin et al 2004).
  - Facilitation of collaboration among physician colleagues
- Fiscal benefits
  - Decreased ER visits, hospital transfers, and hospital admissions (Wegner et al 2008).
  - Potentially significant cost savings. For instance, a study of pediatric subspecialists from six North Carolina academic centers who completed forms to prospectively track telephone consultations with PCPs pertaining to the care of Medicaid patients 22 years of age or younger, found an estimated cost savings of $39 was incurred for each $1 spent on phone consultations (Wegner et al 2008).
  - Savings to patients and families by avoiding unnecessary services, including formal subspecialist consultations and the time, energy, automobile gas, and additional costs of traveling great distances to receive subspecialty care (Wegner et al 2008).
  - Reductions in overall healthcare costs by decreasing the number of investigative tests ordered by PCPs (Dhuriaty 2004; Barker et al 2004; Bendixen et al 2009).

Conversely, opponents of physician reimbursement for phone consultation also cite patient, physician and fiscal concerns of reimbursement for these services.

- Patient concerns
  - May deter poor families from calling with serious problems (Melzer and Poole 2002).
  - May cause patients to transfer their care to practices that do not charge for telephone consultations (Melzer and Poole 2002).

    - Possible patient dissatisfaction with their PCPs if the cost of phone consultations ultimately falls to the patient, and the patient was unaware of this potential cost before it was incurred.
- Physician concerns
    - Subspecialists may be apprehensive over the adequacy and accuracy of phone consultations because of the informal/indirect nature of them (Kuo, Gifford and Stein 1998; Wegner et al 2008).
    - Potential liability for physicians providing such consults.
    - Current lack of reimbursement for time spent on these consultations.
    - Specific documentation requirements for these consultations are ill-defined, especially to discern between levels of telephone consultations.
    - May create the perception that physicians no longer want to "see" patients.
    - May tempt physicians to overuse (or abuse) charging (Melzer and Poole 2002).
    - Potential damage to collegiality among physicians. PCPs may elect not to take advantage of phone consultations in order to protect patients from the potential financial repercussions. This may result in PCPs requesting that the phone consultations not be billed, and may contribute to tension between colleagues and ultimately the detriment of patient care.
- Fiscal concerns
    - If physicians are not reimbursed by third-party payers, they must be willing to bill patients for these phone consultation services. More cost may therefore be shifted to patients.
    - May be viewed as a "hidden" cost in medical care and may therefore require explicit permission from the patient to consult other physicians with the potential for being billed for each consult.
    - May be difficult to trace and confirm telephone consultations, especially without rigorous guidelines for documentation etc.

IV. Relevant AMA Policy

The AMA has broad policy defining quality of care (H-450.995) stating that medical care of high quality should "make efficient use of the technology and other health system resources needed to achieve the desired treatment goal." However, there is no specific policy in place regarding informal phone consultations for new patient care. Policy H-390.859 describes proper uniform compensation, at a fair fee of the physician's choosing, for established patients (defined as previous professional face-to-face contact between the physician and patient) regardless of the form of communication used. The same policy then urges the AMA to press CMS and other third-party payers to acknowledge these communications as separate work rather than the bundling of these communications into existing service codes. AMA policy H-480.961 expands upon H-390.859 and demands that CM "reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation" and specifically requests that these reimbursements occur on an individual claims basis rather than as part of a "fee splitting" or "fee sharing" scheme. In 2000, policy D-70.993 was passed by the AMA and requested proposals to the CPT Editorial Panel to recognize evolving communication forms as extensions of physician work, including telephone consultations, fax, e-mail, video, etc.

V. CPT Coding

Current State of CPT Coding for Telecommunications

The increasing use of telephone and electronic communication for patient care has prompted reimbursement for these services to be recognized as a key policy issue by the AMA. There are currently three CPT codes for telemedicine that define evaluation and management by

physicians of established patients, parents or guardians over the telephone (CPT codes 99441, 99442, and 99443). These codes differ in defining length of interaction: 5-10 minutes, 11-20 minutes, or 21-30 minutes, respectively, and are further classified by assigned RVUs.

After establishment of the above CPT codes, only some Medicaid programs and private insurers are reimbursing physicians for these services. Since the Health Care Financing Administration opened the option for state Medicaid programs to use federal funding for telemedicine, many states have added telemedicine services coverage, although there is a wide range of payment schemes and specific services covered between states. Survey data from 1998-2005 show that 34 states have integrated telemedicine services in Medicaid payment structures. Data about reimbursement from the private sector is limited; one study from the American Telemedicine Association showed that over half of the telemedicine programs in 25 states that were surveyed were receiving payment for billable services (Brown 2006). Medicare, which covers approximately 47.5 million persons, does not cover for any services provided through telemedicine.

As evidenced by the presence of CPT codes for telemedicine and research showing increasing use of telephone communication by doctors, it is clear that the world of telemedicine is growing and is considered important by both health care providers and insurers. The existing CPT codes only define telecommunications between doctors and patients, however. These codes are not applicable to any communication between physicians and other health care professionals, which can comprise a significant part of a physician's workday.

Designing Pertinent CPT Codes for Phone Consultations

Developed in 1966, CPT codes are a registered trademark of the AMA. CPT was adopted for use by the Centers for Medicaid and Medicare Services (CMS) in 1983 and is the cornerstone of billing in the American health sector, alongside providing a basis to conduct actuarial and statistical analysis on procedures and other services. CPT codes are proposed by an array of stakeholders, including medical specialty societies, individual physicians, hospitals, and third-party payers. An application for a CPT code requires a description of the service, the diagnosis of the patient who would use the service, supporting literature for safety and effectiveness, and frequency of procedure. The application is sent to a 17-member CPT editorial panel in the AMA, which is composed of but not limited to physicians from the national medical societies, major private insurers, and CMS. The CPT Advisory Committee, members of whom are nominated from the national medical specialty societies in the AMA House of Delegates, supports the panel with data gathering and expert opinion. The CPT Editorial Panel meets three times a year to consider all applications.

The design of a CPT code to adequately define physician-to-physician consultation is complex. Payment for phone consultations based on time spent is simple to evaluate and record, and can be modeled by other fields such as the legal profession. Physician practices would have to be equipped with methods to document time spent on the phone in consultation, the cost of which would need to be determined. Complexity of consults is another descriptor that could be used and modeled after the already existing CPT coding for in-office consultations, though the subjectivity of telephone consult complexity may be an issue. Using complexity as a descriptor in the CPT coding for phone consultations may result in increasing audits from Medicare and other insurance agencies to verify proper coding. Coding based on complexity may be better for the more experienced physician who can address multiple problems in less time than a newer physician may be able to, whereas time-based coding may be more reflective of the efforts a newer physician puts toward a phone consultation. Potential CPT codes for phone consultation reimbursement could be based on the model similar to that of outpatient office visits, where certain codes are assigned based on either complexity or amount of time spent

counseling a patient. There is data in the literature supporting curbside consultations for improving patient care for both primary and consulting services in large institutions, and also for overall healthcare savings (Grace 2010).

Although the resolution put forth by the AMA-RFS is limited to telephone consultation, it is important also to mention e-consultation. E-consultation is an emerging field that is especially relevant to specialties that deal with picture data, such as retinal pictures in ophthalmology or images in radiology. For example, a question or image is posted online and physician members are able to comment and provide opinions in a 24-hour period. E-consults may serve as an invaluable resource alongside telephone consultations in patient care in the future. Although there is limited data about the usage and financial impact of e-consults, developing CPT codes for reimbursement of e-consults warrants continued discussion.

Potential Reimbursement Alternatives to CPT Codes

Alternatives to CPT coding for physician reimbursement of phone consultation services do exist, but seem unfavorable at this time. Physicians could directly bill other physician offices for the consult, if insurance doesn't pay. This practice may be detrimental to inter-physician collegiality and would add extra expenses to physician offices that sometimes already struggle to maintain overhead costs. If a physician was to directly bill the patient for phone consultations, patients would have to approve of the consultation prior to the telephone call and a greater burden of health costs would be placed on the patient. No reimbursement for phone consultations (i.e. the status quo) is also an option.

VI. Conclusion

The issue of reimbursement for phone consultations provided by physicians is multi-faceted and complex. Patients and physicians agree that time spent in consultation should be reimbursed; however there is currently no formal reimbursement for phone consultations ("curbside consults") provided through CPT coding. The development of CPT codes for reimbursement of physician phone consultations has several positive and negative professional implications and is a very involved process.

VII. Recommendations

Given the timeliness of this topic and current AMA policy supporting reimbursement for other types of physician consultations, the RFS Legislative Advocacy Committee recommends the following:

Recommendation:

1. That our AMA work with all relevant parties to create a method of billing and reimbursement for phone consultations.

This is a timely topic warranting attention by the AMA House of Delegates at this Interim meeting, therefore we call for immediate forwarding of the Phone Consultation Resolution (1; I-10) discussed at the RFS Interim meeting in 2010 to the AMA House of Delegates.

Fiscal Note: TBD

References

Barker G, McNeill KM, Krupinski EA, Weinstein RS. Clinical encounters costing for telemedicine services. *Telemed J E Health* 2004;10(3):381-388.

Bendixen RM et al. Cost effectiveness of a telerehabilitation program to support chronically ill and disabled elders in their homes. *Telemed J E Health* 2009;15(1): 31-38.

Brown NA. State Medicaid and private payer reimbursement for telemedicine: an overview. *J Telemed Telecare* 2006;12 suppl (2):S32-39.

Dhurjaty S. The economics of telerehabilitation. *Telemed J E Health* 2004;10(2):196-199.

Grace C, Alston WK, Ramundo M, Polish L, Kirkpatrick B, Huston C. The complexity, relative value, and financial worth of curbside consultations in an academic infectious disease unit. *Clin Infect Dis* 2010;51(6):651-655.

Krupinski E et al. Telemedicine versus in-person dermatology referrals: an analysis of case complexity. *Telemed J E Health* 2002;8(2):143-147.

Kuo D, Gifford DR, Stein MD. Curbside consultation practices and attitudes among primary care physicians and medical subspecialists. *JAMA* 1998;280:905-909.

Marcin JP et al. Using telemedicine to provide pediatric subspecialty care to children with special health care needs in an underserved rural community. *Pediatrics* 2004;113:1-6.

Melzer SM and Poole SR. Reimbursement for telephone care. *Pediatrics* 2002;109:290. Accessed September 26, 2011. Available at **http://pediatrics.aappublications.org/content/109/2/290.full.html**

Rosenfeld BA et al. Intensive care unit telemedicine: alternate paradigm for providing continuous intensivist care. *Crit Care Med* 2000;28(12):3925-3931.

Wegner SE, Humble CG, Feaganes J, Stiles AD. Estimated savings from paid telephone consultations between subspecialists and primary care physicians. *Pediatrics* 2008;122:e1136. Accessed September 26, 2011. Available at **http://pediatrics.aappublications.org/content/122/6/e1136.full.html**

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report G
(I-11)

Introduced by: Committee on Medical Education

Subject: Report on the Deficiency in Medical Education Relating to Autopsy (Resolution 6, A-11)

Referred to: Reference Committee

I. INTRODUCTION

In order to provide guidance to the RFS-GC and RFS members, the RFS-CME has put together a summary of the discussion points surrounding issues pertaining to the potential deficiency in medical education relating to autopsy. Recent deliberation at the 2011 Annual RFS meeting resulted in a call for further investigation of this trend and proposes interventions to reverse it. Resolution 6 (A-11) would direct the RFS to study areas of deficiency in medical education, identify key interventions to increase autopsy rates and to study potential legislative barriers. The report that follows is the culmination of this work and is respectfully submitted for consideration of the Assembly
at the Interim 2011 meeting.

II. BACKGROUND

Current Policy

It is well documented that rates of autopsy in the US have decreased significantly in the past 50 years [(1)]. This debate is not new to our AMA and there exists significant prior AMA policy to support these initiatives. Policy currently supports revising the accreditation standards for both undergraduate (UGME) and graduate medical education (GME) to require autopsy related training (H-85.989). Policy also asks the Liaison Committee on Medical Education (LCME) - the accreditation body for US allopathic medical schools - to track autopsy rates and report on reasons why it may or may not be a required activity (H-85.969). Often cited as a cause for decreasing autopsy rates, the issue of reimbursement for pathology services at autopsy is also addressed in numerous AMA policy (H-85.989, H-85.985, H-85.978, H-85.964). The College of American Pathologists (CAP) also states (1) The autopsy provides educational resources for training students in the health sciences and for continuing medical education; (2) The autopsy is a valuable tool for medical education, not only for future pathologists, but resident trainees in all disciplines and for the training of medical students. [(2)].

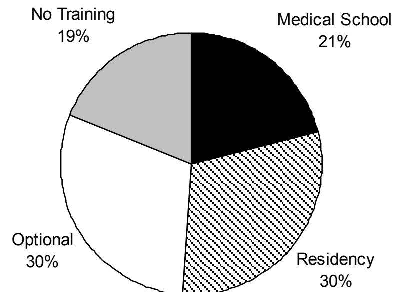
The American Society for Clinical Pathology (ASCP) agrees that autopsy is a valuable tool for medical education. They further recommend that hospitals create policy and procedures which encourage families to consent for an autopsy, provide pamphlets for families to learn about the value of autopsy, and create educational programs for house staff and students on “the implications of interpersonal contacts with families in regard to autopsy permission, including ethnic and religious consideration” (Appendix). Finally, autopsy provides valuable data for quality improvement and vital statistics. A report from the US Department of Health and Human Services states that 75% of death certificates do state the correct cause of death. Several

1 published studies cite high rate for major clinical errors. These errors are only evident when an
2 autopsy is performed.
3
4 The ASCP policy statement 91-01 states several advantages of obtaining autopsies[4]. The
5 practice of autopsy is an important tool that provides "quality assurance of medical diagnosis". It
6 helps in the early identification of environmental, occupational and infectious hazards as well as
7 hazards secondary to bioterrorism. Autopsy can be useful as a measure of evaluating new
8 forms of technology and diagnostic modalities, developing accurate mortality statistics and
9 providing an avenue for both public and physician education. The information gained from
10 autopsy can be usefully employed in future legal, financial and medical matters.
11
12 The ASCP therefore emphasizes the use autopsies in the following situations[4]:
13 1. Deaths in which the autopsy could help explain an unknown cause or complication
14 2. Deaths in which knowing the cause may alleviate concerns of the family or the public as
15 to the cause of death.
16 3. Deaths in patients who have participated in clinical trials.
17 4. All obstetric, neonatal and pediatric deaths.
18 5. Deaths in which the autopsy could disclose or confirm a suspected illness, which may
19 have bearing on the clinical course of the related survivors or the recipients of
20 transplanted organs.
21 6. Unexplained/unexpected causes of death that are not subject to a forensic medical
22 jurisdiction.
23
24 *Declining Rates in Autopsy*
25
26 There has been a growing reliance and confidence on imaging technology to reveal the cause
27 of death, which causes autopsy to be viewed as an added cost. Less than 50% of medical
28 schools in the United States require attendance at autopsies during undergraduate medical
29 education and therefore many medical students graduate without having seen a single autopsy
30 during their training. Furthermore, there does not exist a standardized training platform for
31 residents during graduate medical education to help them understand the importance of autopsy
32 and teach them how to convey this to patient's families. Many physicians are therefore
33 uncomfortable about asking families for autopsies. Additionally, there are inefficiencies and
34 delays inherent in the autopsy process such that reports/results of autopsies do not become
35 available in a timely manner and the information obtained from autopsies is not used to its
36 fullest extent[5-8].
37
38 III. SURVEY RESULTS
39
40 To this end, the AMA-RFS CME developed a survey tool to better understand the experience
41 and opinion of its members. A brief survey was distributed to AMA-RFS members through the
42 listserv and a link to the survey was featured in the AMA Wire, one of our online newsletters.
43 Participants were asked to answer specific questions about their exposure to autopsy training
44 and discussion as well as given the opportunity to comment on the value of autopsy training.
45 Overall, 90 RFS members responded to the survey and all areas of medicine were represented.
46 The majority of respondents have had some means by which they could observe an autopsy,
47 either as part of their medical school or residency curriculum or as an optional activity (Figure
48 1A). Approximately 19% of participants received no exposure to autopsy training. Regardless
49 of experience, 81% of respondents feel as though observing an autopsy would be beneficial to
50 their medical education (Figure 1B).

51

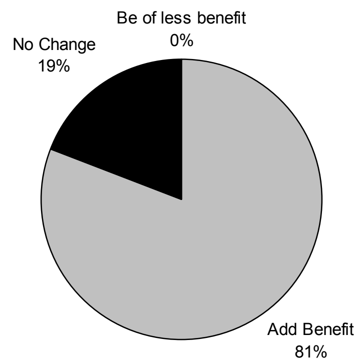
1

During your medical school or residency training, was autopsy observation included in the curriculum?



2

Observing an autopsy would have what effect on your training?

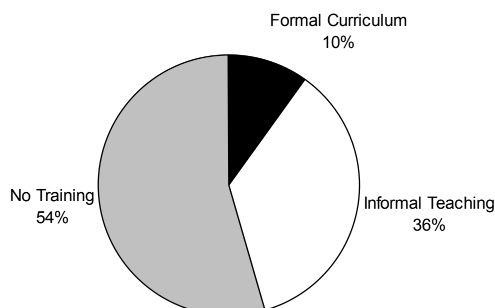


3

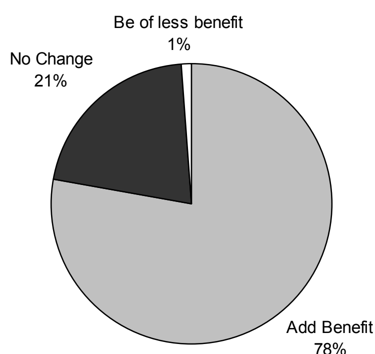
4 **Figure 1.** A) The majority of respondents have observed an autopsy during medical school (21%) or
5 residency training (30%), while for some it was an optional activity (30%). B) The vast majority feel as
6 though observing an autopsy adds benefit to their medical education

7 Regarding autopsy discussions and obtaining consent for an autopsy, a majority 54% of
8 respondents have no training in approaching a patient's family about an autopsy; further, 36%
9 have had informal discussions with faculty, leaving only 10% of respondents with a formal
10 curriculum in autopsy discussion (Figure 2A). The majority of respondents feel as though
11 training in autopsy discussion and results would benefit their medical education (Figure 2B).

12



1



2

Figure 2. A) The majority of respondents have not received training in discussing or requesting an autopsy with patient family members. A formal curriculum was available for 10% of respondents. B) The vast majority feel as though training in autopsy discussion would add benefit to their medical education.

IV. DISCUSSION

In order to help increase rates of autopsies performed, the ASCP encourages hospitals to facilitate, train and encourage clinicians to get consent from the next of kin. It calls for the importance of in-service training programs for nurses and other hospital staff so that they may better learn the reason for autopsy and help in patient education with regard to this issue. It further recommends setting up a body within hospital systems that deals with questions and concerns that patient's families might have about the practice of autopsy. In regard to current medical education policy, only the Residency Review Committee Program Specific Requirements for Pathology (and associated fellowships) require any exposure to autopsy as a condition of accreditation (Appendix). The American College of Physicians does not have a Public Policy statement on autopsy (www.acponline.org search 9/16/2011). Anecdotal reports from residents confirm that autopsy education and consent teaching is rarely addressed in

graduate medical education. This is concerning, as house officers are most likely to be assigned the task of obtaining consent from the family.

Autopsy rates have declined from approximately 60% in the 1950's to less than 6% in recent decades [1]. There have been several proposed reasons for the declining rates such as the perception that other educational rotations are more valuable, the lack of reimbursement for services, physicians perception that current diagnostic testing and imaging renders the results obsolete, and clinicians lack of understanding of its value. Literature cites several other contributing factors to declining autopsy rates: concern for the family's reaction, confidence in clinical diagnosis, lack of exposure in medical training, elimination of Joint Commission suggested autopsy rates, and lack of reimbursement.

While there are barriers identified to increasing autopsy rates, the educational value is well established and there is policy by many of the invested organizations in support of autopsy as both an educational tool and quality assurance measure. Increasing autopsy rates would require coordinated efforts by both UGME and ACGME as well as support by the JCO, CMS, and AHRQ among others.

In addition to the declining rates of autopsies performed, there is an identified need for formal training in approaching families in discussing the benefit of an autopsy and obtaining consent. While many of the AMA-RFS members have observed an autopsy as part of their training, only 10% of respondents have received training in this important and often sensitive discussion with the next of kin. To the best of our knowledge, no standard educational tool exists.

V. RECOMMENDATIONS

Given our review of current policy, medical literature, and brief member survey, the AMA-RFS Committee on Medical Education recommends the following:

1. That our AMA continue to work with all relevant organizations to advocate for participation in an autopsy during medical school or residency training.

2. That our AMA continue to work with all relevant organizations to overcome legislative and other barriers to improve autopsy rates.

3. That our AMA (RFS) work with all relevant parties to develop a standard curriculum or teaching module on discussion of autopsy, obtaining consent, and autopsy results as part of a patient care specialty.

REFERENCES

1. Xiao J._Am J Med Sci. 2009 Jan;337(1):41-6

2. www.cap.org. Accessed 8/15/2011

3. **Stolman CJ, Castello F, Yorio M, et al.** Attitudes of pediatricians and pediatric residents toward obtaining the permission for autopsy. Arch Pediatr Adolesc Med 1994;148:843–7.

4. American Society of Clinical Pathology (ASCP) Policy Number 91-01.

5. Loughrey MB, McCluggage WG, Toner PG. The declining autopsy rate and clinicians' attitudes. Ulst Med J 2000;69:83-9

6. Lundberg GD. Medicine without the autopsy. Arch Pathol Lab Med 1984;108:449-54.

7. Welsh TS, Kaplan J. The role of postmortem examination in medical education. Mayo Clin Proc 1998;73:802-5.

8. Hartmann, HRF, Sebastian M. An argument for the attendance of clinicians at autopsy. Arch Pathol Lab Med 1984;108:522-3.

Relevant AMA Policy:

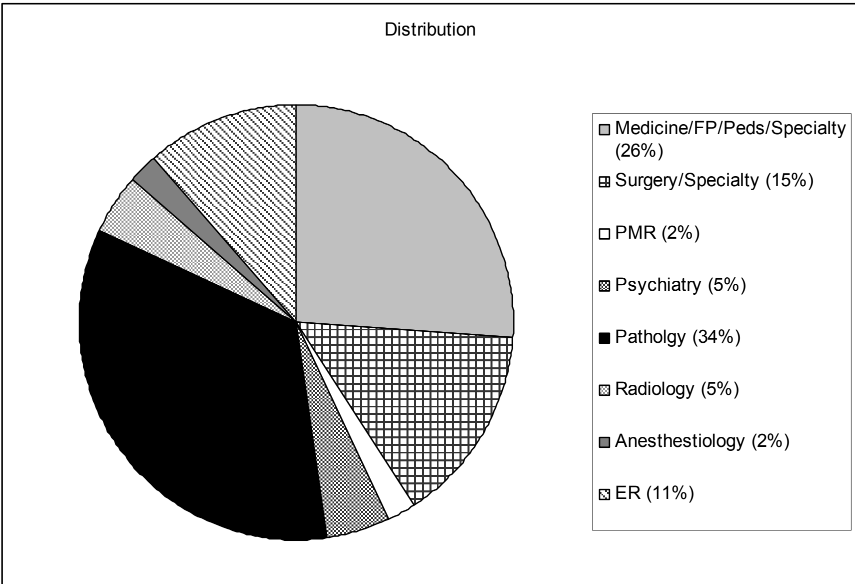
H-85.989 Autopsies
The AMA (1) endorses the efforts of the Institute of Medicine and other national organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (2) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (3) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (4) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (5) requests the JCAHO to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (6) endorses the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (7) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (8) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals. (CSA Rep. G, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 703, A-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-85.985 Minimum Autopsy Rates for Teaching Hospitals
The AMA (1) urges the federal government to provide for payment, under its programs, for autopsies as a valuable element in determining the quality of medical care and enhancing the quality of medical education; (2) reaffirms its current policy regarding autopsies, which (a) proposes ways to increase the utilization and effectiveness of the autopsy; (b) supports the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates; and (c) urges government reimbursement for autopsy to signify its recognition as a necessary medical procedure. (Sub. Res. 79, A-87; Reaffirmed by Sub. Res. 703, A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07)

H-85.993 Autopsies

1 The AMA (1) reaffirms the fundamental importance of the autopsy in any effective hospital quality
2 assurance program; and (2) urges physicians and hospitals to increase the utilization of the autopsy so as
3 to further advance the cause of medical education, research and quality assurance. (Sub. Res. 11, A-84;
4 Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04)
5
6 **H-85.978 Autopsy as the Practice of Medicine**
7 It is the policy of our AMA: (1) that the performance of autopsies constitutes the practice of medicine; (2)
8 in conjunction with the pathology associations represented in the AMA House, to continue to implement
9 all the recommendations regarding the effects of decreased utilization of autopsy on medical education
10 and research, quality assurance programs, insurance claims processing, and cost containment; and (3) to
11 initiate a program for the appropriate reimbursement of autopsies including efforts aimed at having the
12 autopsy take its rightful place as a Medicare Part B reimbursable physician service. (Sub. Res. 172, A-90;
13 Modified: Res. 512, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)
14
15 **H-85.969 Preserving the Vital Role of the Autopsy in Medical Education**
16 The AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and
17 student participation in autopsies continue to be monitored periodically and that the reasons that schools
18 do or do not require attendance be collected. (2) The AMA will continue to work with other interested
19 groups to increase the rate of autopsy attendance. (CME Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)
20
21 **H-85.964 Autopsy Payment and Performance Standards for Third Party Payers**
22 Our AMA: (1) request that the National Committee on Quality Assurance (NCQA) and other accrediting
23 bodies encourage the performance of autopsies to yield benchmark information for all managed care
24 entities seeking accreditation; (2) calls upon all third party payers, including CMS, to provide adequate
25 payment directly for autopsies; and (3) encourages adequate reimbursement by all third party payers for
26 autopsies. (Sub. Res. 703, A-97; Modified: Sub. Res. 801, A-00; Reaffirmation I-00; Reaffirmed: CMS
27 Rep. 6, A-10)
28
29 **H-85.993 Autopsies**
30 The AMA (1) reaffirms the fundamental importance of the autopsy in any effective hospital quality
31 assurance program; and (2) urges physicians and hospitals to increase the utilization of the autopsy so as
32 to further advance the cause of medical education, research and quality assurance. (Sub. Res. 11, A-84;
33 Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6,A-04)
34
35 **H-85.980 Autopsy for Pathological Correlation**
36 Our AMA (1) supports seeking the cooperation of the National Advisory Council on Aging of the National
37 Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities,
38 and most importantly the American people the necessity of autopsy for pathological correlation of the
39 results of the immeasurable scientific advancements which have occurred in recent years; (2) believes
40 that the information garnered from such stringent scientific advancements and correlation, as well as
41 coalitions, should be used in the most advantageous fashion; and (3) believes that the conclusions
42 obtained from such investigations should be widely shared with the medical and research community and
43 should be interpreted by these groups with the utmost scrutiny and objectivity. (Res. 61, I-89; Reaffirmed:
44 Sunset Report, A-00;Reaffirmed: CSAPH Rep. 1, A-10)
45

1 Appendix Figure. Survey Respondent Demographics
2
3



4

1 **The College of American Pathologists Statement**
2
3 www.cap.org
4 http://www.cap.org/apps/cap.portal?_nfpb=true&cntvwrPtlt_actionOverride=%2Fportlets%2FcontentViewe
5 r%2Fshow&_windowLabel=cntvwrPtlt&cntvwrPtlt{actionForm.contentReference}=spokespersons%2Ftalki
6 ng_points%2Ftalking_points_autopsy.html&_state=maximized&_pageLabel=cntvwr
7
8 Updated January 12, 2010
9
10 The autopsy is a valuable medical tool and resource for assessing the quality of patient care.
11 Top Points
12 Autopsy data can be an important health care outcome measure by which to draw conclusions about
13 the quality of patient care and to guide corrective action as necessary.
14 The hospital autopsy is a valuable quality assurance tool for evaluating clinical diagnostic accuracy and
15 determining the effectiveness and impact of therapeutic regimens.
16 The autopsy can discover and define new and/or changing diseases and increase medical science's
17 understanding of biological processes of disease, augmenting clinical and basic research.
18 The autopsy can provide information on genetic diseases, which can assist survivors through
19 counseling in future diagnosis and treatment.
20 The autopsy is critical in organ and tissue transplantation to detect unsuspected infectious or neoplastic
21 conditions that could be transmitted to recipients, thus protecting the integrity of tissue and organ
22 transplantation.
23 Through the efforts of pathologists in cooperation with other dedicated physicians, the living are direct
24 beneficiaries of the autopsy.
25 The autopsy provides accurate public health and vital statistical information and education as it relates
26 to diseases.
27 The autopsy provides medicolegal factual information for risk management to resolve issues regarding
28 hospital deaths.
29 The autopsy can give peace of mind to surviving family members by helping to answer questions about
30 the death and to relieve anxiety about what might have happened.
31 The autopsy provides educational resources for training students in the health sciences and for
32 continuing medical education.
33 The autopsy is a valuable tool for medical education, not only for future pathologists, but resident
34 trainees in all disciplines and for the training of medical students.
35 Even an autopsy that does not reveal anything unexpected can be valuable, because it can provide
36 great comfort to the family to know, for sure, that the patient was correctly diagnosed and treated.
37 Suggested "As a Physician Who Specializes in Pathology" Statement(s)
38 As a physician who specializes in pathology, I know the importance of autopsy data in determining the
39 cause of death to assist in future diagnosis and treatment for the living.
40 -OR-
41 As a physician who specializes in pathology, I know that an autopsy can provide important medical and
42 legal factual information in the interest of public health and safety.
43 Supporting Points
44 Pathologists, physicians who study tissues and cells to identify and diagnose disease, know that the
45 autopsy provides vital factual medical and legal information in the interest of public health and safety.
46 The College of American Pathologists recommends that a request be made for autopsy on every death.
47 The College recognizes, however, that performing an autopsy on every death may not be possible and
48 that every institution should establish specific recommendations.
49 The autopsy provokes controversy. It is expensive, time consuming, poorly understood, and not well
50 compensated.
51 Because the exigencies of managed care have reduced the number of laboratory personnel available
52 to fulfill the priority of serving the needs of live patients, physicians are less likely to seek permission for
53 autopsies.
54 The number of autopsies performed has declined for several reasons. Some of them are:
55 o Cost-cutting pressures.
56 o Perception that technologic advances have rendered the autopsy obsolete.
57 o Patients and clinicians don't understand the value of the autopsy.
58 o Fear of malpractice litigation.

1 In most cases, the autopsy actually prevents litigation, as it disproves allegations of negligence and/or
2 malpractice.
3 o Lack of Direct Reimbursement discourages the performance of autopsies by community pathologists.
4 o Perception in residency programs that rotations other than autopsy are more valuable for training.
5 o Misconception that autopsy precludes viewing at the time of the funeral or is prohibited by one's
6 religion.

Resolution 6. (AMA-RFS, A-11) "Deficiency in Medical Education Relating to Autopsy"

Whereas, Autopsy rates have declined from approximately 60% in the 1950's to less than 6% in recent decades,[1] and

Whereas, Multiple studies have demonstrated the benefits for autopsy for patients' families, including: identifying the nature of disease and possible health risks for family members, verification of appropriate and adequate medical care given to loved one, and contribution to medical knowledge,2 and

Whereas, The benefit of autopsy to health care providers and the field of medicine in general remains relevant in the face of advanced medical technologies (including radiological testing), with studies estimating the rate of missed diagnoses involving primary cause of death to be 8.4% - 24.4% by autopsy,3 and a case series identifying that in 44.4% of these types of cases, therapy would have been altered with knowledge of the correct diagnosis,4 and

Whereas, Although many studies have identified physician behavior as a barrier due to a lack of knowledge and training,5,6 there has been no concerted effort to study specific areas for intervention and the efficacy of possible interventions in medical education for autopsies, and

Whereas, Both the Institute of Medicine and the Department of Health and Human Services have prevention of medical errors as a major focus,7 the use of the "gold standard" for quality care, the autopsy, has not been focused on and

Whereas, As an example for Internal Medicine residencies, the ACGME mandates that residents "systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement;" as part of the core competency of Practice-based Learning and Improvement,8 yet there has been no focus on utilization of autopsy, and

Whereas, In addition to the reasons listed above, improvement of the rate of autopsies by medical education will have other major ramifications on health care, by contributing to knowledge of geographic and environmental forces that affect health,9 impacting public health efforts with more reliable and accurate data and surveillance,7 and improving health delivery with evaluation of quality of care, and

Whereas, There is literature available identifying barriers to autopsy which shows that historical factors, such as the removal of the autopsy quota requirement from the Joint Commission as well as the shift away from reimbursement of autopsy by Medicare and most insurers,7,10 also contribute in large part to the declining rate in autopsies, therefore be it

RESOLVED, That the AMA-RFS study areas of deficiency in medical education relating to autopsy in medical school and residency, in order to identify key interventions in medical education that will have the largest impact in increasing autopsy rates (including but not limited to mandating participation in an autopsy during medical school and multiple educational sessions about autopsies for residents), and be it further

RESOLVED, That the AMA-RFS study potential legislative barriers to autopsy and potential efforts to improve autopsy rates, and be it further

RESOLVED, that the AMA-RFS report back at I-11.