

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1  
(A-18)

Introduced by: Luke V. Selby, MD, MS and Jason Hall, MD, JD

Subject: Naming Conventions for AMA-RFS Policy

Referred to: Reference Committee

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Whereas, The AMA-RFS has for years produced independent, internal policy to guide our Section's deliberations and establish institutional memory; and

Whereas, Some policy originating within the RFS is forwarded from the AMA-RFS Assembly to the AMA House of Delegates (HOD); and

Whereas, Traditionally resolutions written as "internal policy" direct "our AMA-RFS" to take some action while resolutions written as "external policy" direct "our AMA" to take some action; and

Whereas, Having AMA-RFS policy directing the AMA to take action on an item presents numerous governance conflicts; and

Whereas, When it comes to matters of external policy discussions policy of the AMA-HOD takes precedence over policy of any of the AMA sections, including the AMA-RFS; and

Whereas, It is in the best interests of the AMA-RFS to have an accurate record of internal policy discussions and keep an up to date policy compendium and digest of actions, with regular sunset review of these actions; therefore be it

RESOLVED, That all policies within the AMA-RFS digest of actions reading "our AMA" be editorially changed to read "our AMA-RFS" without changing the sunset date (Directive to Take Action); and be it further

RESOLVED, That beginning at I-18, all resolutions brought to the AMA-RFS Assembly be written "our AMA-RFS" with a separate resolved clause included as necessary to have the resolutions (or selected resolved clauses within the resolution) forwarded to the AMA House of Delegates at a specific meeting (New RFS Policy); and be it further

RESOLVED, That any resolution forwarded from the AMA-RFS to the AMA House of Delegates (HOD) be editorially changed from reading "our AMA-RFS" to "our AMA" in the version submitted to the AMA HOD. (New RFS Policy)

Fiscal Note: Minimal

**RELEVANT AMA AND RFS POLICY**

**[Introducing Business to the AMA House G-600.060](#)**

AMA policy on introducing business to our AMA House includes the following: 1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance.

The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website. 2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement. 3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process. 4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution. 5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts. 6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates. 7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House. 8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years. 9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House.

#### Procedure. B-2.11

2.11.1 Order of Business. The Order of Business will be proposed by the Speaker and approved by the House of Delegates. At any meeting, the House of Delegates, by majority vote, may change the order of business.

2.11.2 Privilege of the Floor. The House of Delegates, by a two-thirds vote of delegates present and voting, may extend to any person an invitation to address the House.

#### 2.11.3 Introduction of Business.

2.11.3.1 Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 30 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1 Exempted Resolutions. If any member organization's house of delegates or primary policy making body, as defined by the organization, adjourns during the 5-week period preceding commencement of an AMA House of Delegates meeting, the organization is allowed 7 days after the close of its meeting to submit resolutions to the AMA. All such resolutions must be received by noon of the day before the commencement of the AMA House of Delegates meeting. The presiding officer of the organization shall certify that the resolution was adopted at its just concluded meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.

2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates no later than the recess of the House of Delegates opening session to be accepted as regular business. Resolutions presented after the recess of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.4.

2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

2.11.3.1.5 Withdrawal of Resolutions. A resolution may be withdrawn by its sponsor at any time prior to its acceptance as business by the House of Delegates.

2.11.3.1.6 Resolutions not Accepted. Late resolutions and emergency resolutions not accepted as business by the House of Delegates may be submitted for consideration at a future meeting in accordance with the procedure in Bylaw 2.11.3.

2.11.3.2 Business from the Board of Trustees. Reports, recommendations, resolutions or other new business, may be presented by the Board of Trustees at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.3 Business from the Councils. Reports, opinions or recommendations from a council of the AMA or a special committee of the House of Delegates may be presented at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.4 Informational Reports of Sections. Informational reports may be presented by the AMA Sections on an annual basis.

2.11.4 Referral to Reference Committee. Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates. Items of business presented after the recess of the opening session are not referred to reference committee, but rather heard by the House of Delegates as a whole, subject to acceptance as business of the House of Delegates. Informational items are not referred to a reference committee.

2.11.6 Quorum. A majority of the voting members of the House of Delegates Official Call shall constitute a quorum.

#### Business Meeting. B-7.0.6

There shall be a Business Meeting of members of each Section. The Business Meeting shall be held on a day prior to each Annual and Interim Meeting of the House of Delegates.

7.0.6.1 Purpose. The purposes of the Business Meeting shall be:

7.0.6.1.1 To hear such reports as may be appropriate.

7.0.6.1.2 To consider other business and vote upon such matters as may properly come before the meeting.

7.0.6.1.3 To adopt resolutions for submission by the Section to the House of Delegates.

7.0.6.1.4 To hold elections.

7.0.6.2 Meeting Procedure.

7.0.6.2.1 The Business Meeting shall be open to all members of the AMA.

7.0.6.2.2 Only duly selected representatives who are AMA members shall have the right to vote at the Business Meeting.

7.0.6.2.3 The Business Meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council. The rules of procedure may specify the rights and privileges of Section members, including any limitations on participation or vote.

#### **580.009R AMA-RFS External Resolutions**

That our AMA-RFS include in the AMA-RFS delegate package and in the AMA-RFS Handbook information explaining the options for each resolution and the process for determining how resolutions are forwarded to either the AMA-RFS assembly and/or the AMA-HOD. (Substitute Resolution 5, I-97) (Reaffirmed Report C, I-07)

**580.019R AMA-RFS Sunset Mechanism Procedure**

(1) That our AMA-RFS Governing Council present actionable sunset recommendations to RFS policy via a yearly report at our Annual Meeting; (2) That each adopted resolve or recommendation clause within an RFS policy shall be considered individually with regard to the sunset process; (3) That our AMA-RFS annually review ten-year-old RFS policies and recommend whether to (a) reaffirm the policy, (b) rescind the policy, (c) reconcile the policy with more recent and like policy, or (d) make editorial changes which maintain the original intent of the policy; (4) That each RFS sunset recommendation regarding RFS policy may be extracted from the Consent Calendar and handled individually by our Assembly, but may only be adopted or not adopted; (5) That an action of the RFS Assembly that retains or updates an existing RFS policy shall reset the sunset "clock," making the reaffirmed RFS policy viable for ten additional years; (6) That defeated RFS sunset recommendations be reaffirmed for one year, to be readdressed via RFS Governing Council report or resolution from the RFS Assembly at or prior to the next RFS Annual Meeting; and (7) That nothing in this policy shall prohibit a report or resolution to sunset an RFS policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current RFS policy, or has been accomplished. (Report E, I-17)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 2  
(A-18)

Introduced by: Sean Figy, MD  
Subject: Comprehensive Breast Cancer Treatment  
Referred to: Reference Committee

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Whereas, The Women's Health and Cancer Rights Act of 1998 (WHRCA) mandates that insurance providers cover reconstructive procedures after mastectomy; and

Whereas, Some insurers have interpreted this language as only covering total mastectomies and not partial mastectomies or lumpectomies and thus deny coverage of reconstructive surgery for patients with deformities after lumpectomies and after radiation; and

Whereas, Breast Conservation Therapy is often an oncologically safe option for patients, which may leave the breast disfigured; and

Whereas, Radiation therapy in and of itself can lead to pain, fibrosis and deformity of a post-treatment breast; and

Whereas, Technology and techniques for correcting post-lumpectomy and post-radiation deformities have improved and increased, yet insurance interpretation of the WHRCA benefit may limit women's access to corrective surgery, oncoplastic reconstruction and fat grafting; and

Whereas, Breast reconstruction has been shown to significantly increase physical, social and sexual well-being<sup>1</sup>; therefore be it

RESOLVED, That our AMA: (1) believes that reconstruction of the breast for rehabilitation of the post-treatment cancer patient should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided (New RFS Policy); and be it further

RESOLVED, That our AMA acknowledge that access to breast reconstruction is a pivotal part of the breast cancer care pathway (New RFS Policy); and be it further

RESOLVED, That our AMA advocate that reconstructive techniques for partial mastectomy be

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<sup>1</sup> [Eltahir Y<sup>1</sup>](#), [Werners LL](#), [Dreise MM](#), [van Emmichoven IA](#), [Jansen L](#), [Werker PM](#), de Bock GH. Quality-of-life outcomes between mastectomy alone and breast reconstruction: comparison of patient-reported BREAST-Q and other health-related quality-of-life measures. [Plast Reconstr Surg.](#) 2013 Aug;132(2):201e-209e. doi: 10.1097/PRS.0b013e31829586a7.

covered to the same degree as reconstruction following complete mastectomy (New RFS Policy); and be it further

RESOLVED, That our AMA amend Policy H-55.973 by addition and deletion as follows

Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the ~~postmastectomy~~ post treatment cancer patient should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided. (Amend HOD Policy)

Fiscal Note: Minimal

#### **RELEVANT AMA AND RFS POLICY**

##### **[Breast Reconstruction H-55.973](#)**

Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the postmastectomy cancer patient should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided.

AMERICAN MEDICAL ASSOCIATION RESIDENT FELLOW SECTION

Resolution: 3  
(A-18)

Introduced by: Sarah Marsicek, MD; Zarah Iqbal, MD; American Academy of Pediatrics  
Subject: Mandating Critical Congenital Heart Defect Screening in Newborns  
Referred to: RFS Delegate

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Whereas, Approximately 18 out of every 10,000 infants are born with a critical congenital heart defect (CCHD)<sup>1</sup>; and

Whereas, CCHDs are life-threatening and often require intervention during infancy<sup>1</sup>; and

Whereas, Many CCHDs are not detected prenatally or in the immediate post-natal period<sup>1</sup>; and

Whereas, The pulse oximetry screening protocol is a low-cost and sensitive screen that can be used to detect CCHD; and

Whereas, A 2013 study in *Pediatrics* estimated screening could potentially identify 1,189 more newborns with CCHD at birth hospitals in the United States annually and screening may cost approximately \$40,000 per life-year saved, which is considered cost-effective<sup>2</sup>; and

Whereas, Our AMA has policy in support of standardized newborn screening (H-245.973) and newborn hearing screening (H-245.970); and

Whereas, 43 states have taken steps toward newborn screening through legislation, regulations, and hospital guidelines, 35 of which have legislation mandating screening for congenital heart defects<sup>3</sup>; therefore be it

RESOLVED, That our AMA supports mandated screening for critical congenital heart defects by pulse oximetry for newborns following delivery prior to hospital discharge. (New HOD Policy)

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<sup>1</sup> American Academy of Pediatrics. (2018) "Newborn Screening for CCHD." Available at <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Newborn-Screening-for-CCHD.aspx>

<sup>2</sup> Peterson C, Grosse S, Oster M, Olney R, and Cassell C. Cost-effectiveness of routine screening for critical congenital heart disease in US newborns. *Pediatrics* 2013; 132(3).

<sup>3</sup> Glidewell J, Olney RS, Hinton C, Pawelski J, Sontag M, Wood T, Kucik J; Daskalov R, Hudson J. State Legislation, Regulations, and Hospital Guidelines for Newborn Screening for Critical Congenital Heart Defects — United States, 2011–2014. *CDC Weekly Morbidity and Mortality Report*. 19 June 2015: 64(23);625-630.

Fiscal Note: Moderate

#### RELEVANT AMA AND RFS POLICY

##### **Standardization of Newborn Screening Programs H-245.973**

Our AMA: (1) recognizes the need for uniform minimum **newborn screening** (NBS) recommendations; and (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases. (CSAPH Rep. 9, A-06; Reaffirmed in lieu of Res. 502, A-09)

##### **Early Hearing Detection and Intervention H-245.970**

Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing **screening**, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing **screening** of newborns and infants, prompt evaluation and diagnosis of children referred from **screening** programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss. (Res. 514, A-11; Reaffirmed: CMS Rep. 6, I-15)



AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 4  
(A-18)

Introduced by: Fakhra Khalid, MD

Subject: Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients

Referred to: Reference Committee

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Whereas, Cancer treatments in younger patients can lead to reduced fertility<sup>1</sup>; and

Whereas, Studies have demonstrated that oncology patients are interested in the option of fertility preservation<sup>2</sup>; and

Whereas, There are several methods to help preserve fertility in pediatric and reproductive aged patients including cryopreserving embryos, oocytes, sperm, or gonadal tissue<sup>1</sup>; and

Whereas, Fertility preservation has not been associated with delayed cancer treatment or decreased survival; and

Whereas, There are significant geographic and clinic variations in the support for fertility preservation amongst oncologists and fertility specialists; and

Whereas, There is a lack of adequate provision of information on fertility preservation and lack of referral to fertility clinics for pediatric and reproductive aged oncology patients often resulting from oncologist discomfort in providing adequate counseling to such patients<sup>1</sup>; and

Whereas, There is a significant disparity in access to fertility preservation for pediatric and reproductive aged oncology patients; therefore be it

RESOLVED, That our AMA encourage full disclosure to cancer patients on risks to fertility when gonadotoxicity due to cancer treatment is unavoidable (New RFS Policy); and be it further

RESOLVED, That our AMA support enhanced training of pediatric oncology fellows and reproductive endocrinology fellows in providing thorough counseling to oncology patients who may benefit from fertility preservation. (New RFS Policy)

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<sup>1</sup> The Ethics Committee of the American Society for Reproductive Medicine. "Fertility Preservation and Reproduction in Cancer Patients." *Ethics Committee Report*, Elsevier, Inc, 11 Mar. 2005, [oncofertility.northwestern.edu/sites/oncofertility/files/legacy\\_files/uploadedfilecontent/ASRM\\_FP\\_in\\_Cancer\\_2005.pdf](http://oncofertility.northwestern.edu/sites/oncofertility/files/legacy_files/uploadedfilecontent/ASRM_FP_in_Cancer_2005.pdf)

<sup>2</sup> National Comprehensive Cancer Network. *NCCN Guidelines Version 2.2018 Adolescent and Young Adult Oncology*. 11 Oct. 2017.

Fiscal Note: Minimal

**RELEVANT AMA AND RFS POLICY**

**[Infertility and Fertility Preservation Insurance Coverage H-185.990](#)**

Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility. 2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation.

**[390.007R Oncofertility and Fertility Preservation Treatment](#)**

That our AMA: (1) support coverage for standard fertility preservation therapy by all payers when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician; and (2) advocate for appropriate legislation requiring coverage for fertility preservation therapy services when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician. (Resolution 6, A-12)

[Code of Medical Ethics: Opinion 2.1.1 Informed Consent](#)

[Code of Medical Ethics: Opinion 2.1.3 Withholding Information from Patients](#)

[Code of Medical Ethics: Opinion 2.2.1 Pediatric Decision Making](#)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 5  
(A-18)

Introduced by: Fakhra Khalid, MD

Subject: Removal of the Food and Drug Administration Risk Evaluation and Mitigation Strategy for Mifepristone Use in Early Pregnancy Failure

Referred to: Reference Committee

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Whereas, Mifepristone has been demonstrated to have higher efficacy than misoprostol alone for the treatment of early pregnancy failure<sup>1</sup>; and

Whereas, The FDA mandates a Risk Evaluation and Mitigation Strategy (REMS) for mifepristone requiring that it be dispensed by a healthcare provider meeting certain qualifications, and requiring both the provider and the patient to complete agreement forms<sup>2</sup>; and

Whereas, Early pregnancy failure can be diagnosed with a bedside transvaginal ultrasound by a general Ob-Gyn<sup>3</sup>; and

Whereas, Many practitioners in Ob-Gyn clinics do not meet the criteria for administration of mifepristone for early pregnancy failure; and

Whereas, This may delay care for a patient who has suffered an early pregnancy failure; therefore be it

RESOLVED, That our AMA encourage the FDA to remove Risk Evaluation and Mitigation Strategy for mifepristone in early pregnancy failure (Directive to Take Action); and further be it

RESOLVED, That our AMA increase education and training of practitioners who diagnose and are allowed to treat early pregnancy failure with mifepristone rather than an inferior regimen. (New AMA Policy)

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<sup>1</sup> Colleselli V, Nell T, Bartosik T, Brunner C, Ciresa-Koenig A, Wildt L, Marth C, Seeber B. Marked improvement in the success rate of medical management of early pregnancy failure following the implementation of a novel institutional protocol and treatment guidelines: a follow-up study. *Arch Gynecol Obstet.* 2016 Nov;294(6):1265-1272. Epub 2016 Aug 23. Available at [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5071363/pdf/404\\_2016\\_Article\\_4179.pdf](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5071363/pdf/404_2016_Article_4179.pdf).

<sup>2</sup> "Drug Safety and Availability - Mifeprex (Mifepristone) Information." *U S Food and Drug Administration Home Page*, Center for Drug Evaluation and Research, [www.fda.gov/Drugs/DrugSafety/ucm111323.htm](http://www.fda.gov/Drugs/DrugSafety/ucm111323.htm).

<sup>3</sup> Bizjak I, Fiala C, Berggren L, Hognert H, Sääv I, Bring J, Gemzell-Danielsson K. Efficacy and safety of very early medical termination of pregnancy: a cohort study. *BJOG.* 2017 Dec;124(13):1993-1999. doi: 10.1111/1471-0528.14904. Epub 2017 Sep 27.

Fiscal Note: Minimal

**RELEVANT AMA AND RFS POLICY**

**Medical Training and Termination of Pregnancy H-295.923**

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. Further, the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.

2. Our AMA encourages the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American Congress of Obstetricians and Gynecologists recommendations.

**Right to Privacy in Termination of Pregnancy H-5.993**

The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 6  
(A-18)

Introduced by: Tani Malhotra, MD; Sean Figy, MD; Amar Kelkar, MD; Luke Selby, MD; and  
Gunjan Malhotra, MD

Subject: Access to Care

Referred to: Reference Committee

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Whereas, The Association of American Medical Colleges predicts a physician shortage of more than 100,000 doctors by the year 2030<sup>1</sup>; and

Whereas, International Medical Graduates (IMGs) are more likely to practice in primary care specialties than US medical graduates<sup>2</sup>; and

Whereas, Foreign-born IMGs were more likely to practice in rural underserved areas than US born IMGs<sup>2</sup>; and

Whereas, The Education Council of Foreign Medical Graduates (ECFMG) sponsors approximately 10,000 J-1 visas annually; and

Whereas, The ECFMG prohibits physicians with a J-1 visa from moonlighting based on the US Code of Federal Regulations 22CFR62.16<sup>3</sup>, and subsequently prohibits physicians with J-1 visas privileges to bill for services rendered; and

Whereas, Providing physicians with a J-1 visa billing privileges and to the ability to moonlight may improve the access to care in certain areas; therefore be it

RESOLVED, Our AMA-RFS advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to bill Medicare and Medicaid (Directive to Take Action); and be it further

RESOLVED, That this resolution be forwarded to the AMA House of Delegates at I-18. (Directive to Take Action)

Fiscal Note: Minimal

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<sup>1</sup> Research Shows Shortage of More than 100,000 Doctors by 2030. Available at: <https://news.aamc.org/medical-education/article/new-aamc-research-reaffirms-looming-physician-shor/>.

<sup>2</sup> International Medical Graduates and The Primary Care Workforce For Rural Underserved Areas. Available at <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.22.2.255>.

<sup>3</sup> Employment Outside of the Approved Training Program ("Moonlighting"). Available at <https://www.ecfm.org/evsp/evspemot.pdf>.

**RELEVANT AMA AND RFS POLICY**

**[Employment of Non-Certified IMGs H-255.970](#)**

Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs.

**220.001R Employment of Non-Certified Foreign Medical Graduates**

That our AMA (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met State criteria for full licensure;(2) encourage states that have difficult recruiting doctors to underserved areas explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs. (Resolution 2, A-03) (Reaffirmed Report D, I-13) [Current AMA policy reaffirmed in lieu of AMA Resolution 206, A-03; AMA Resolution 309 adopted in lieu of Resolution 319 brought by RFS.]

**220.002R Restoration of J-1 Visa Waivers for Underserved Communities**

That our AMA work to restore and maintain programs by federal agencies and state governments through which an adequate number of international medical graduates may obtain J-1 visa waivers to provide medical services in underserved communities. (Resolution 10, A-02) (Reaffirmed Report D, I-12)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 8  
(A-18)

Introduced by: Gunjan Malhotra, MD; Amar Kelkar, MD; Tani Malhotra, MD; Luke Selby, MD; Naiim Ali, MD; and Sean Figy, MD

Subject: Medical Technology and Artificial Intelligence: Regulation and Oversight Requirements by the Food and Drug Administration

Referred to: Reference Committee

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Whereas, There is promise with the addition of technological innovation in medicine generally defined as artificial intelligence; and

Whereas, This promise comes in the form of research, projects, devices and applications aimed at supporting and improving the performance of licensed health care providers; and

Whereas, These research, projects, devices and applications should undergo experimental evaluation and FDA approval with input of licensed medical professionals to verify clinical applicability, safety, and accuracy; and

Whereas, The HIPAA Privacy Rule (45 CFR Part 160) allows patients to inspect, review, and receive a copy of their medical records and billing records<sup>1,2</sup>; and

Whereas, The FDA has issued warnings in the past regarding products marketed direct to consumers without oversight by licensed medical professionals (i.e., “keepsake ultrasounds”)<sup>3</sup>; and

Whereas, FDA warnings have set a precedence for informing patients about the use of technology outside the confines of licensed medical professionals and their intended safe indicated uses; and

Whereas, There will likely be continued technological innovation and investment with subsequent marketing of these products directly to patients, bypassing health care professionals and FDA approval; and

Whereas, Patients themselves, with their legally obtained medical and billing records, may seek out services and companies using artificial intelligence that have not yet shown true clinical applicability, safety and accuracy; and

Whereas, Any future direct-to-consumer marketing of artificial intelligence as it relates to human health should be required to bare a warning if not FDA approved; therefore be it

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<sup>1</sup>Your Medical Records. Available at <https://www.hhs.gov/hipaa/for-individuals/medical-records/index.html>.

<sup>2</sup>The HIPAA Privacy Rule. Available at <https://www.hhs.gov/hipaa/for-professionals/privacy/index.html>.

<sup>3</sup>Avoid Fetal "Keepsake" Images, Heartbeat Monitors. Available at <https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm095508.htm>.

RESOLVED, That our American Medical Association (AMA) work with the Food and Drug Administration (FDA) to ensure that warnings are issued when artificial intelligence and technological innovations, regarding human health, are used for purposes outside their intended FDA approved medical use by individuals that are not licensed medical professionals (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the FDA to restrict use of artificial intelligence and technological innovations in medicine and human health to be in consult with physicians and physician-led health care teams comprised of licensed medical professionals after verification of clinical applicability, safety, and accuracy. (Directive to Take Action)

Fiscal Note: Moderate

#### **RELEVANT AMA AND RFS POLICY**

##### **[Allocation of Privileges to Use Health Care Technologies H-480.988](#)**

The AMA (1) affirms the need for the Association and specialty societies to enhance their leadership role in providing guidance on the training, experience and knowledge necessary for the application of specific health care technologies; (2) urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and (3) asserts that licensure of physicians by states must be based on scientific and clinical criteria.

##### **[Medical Device Amendments of the FDA H-480.996](#)**

(1) The AMA reiterates its concerns regarding the implementation of the Medical Device Amendments to the Food and Drug Administration (FDA) and urges that regulations be promulgated or interpreted so as to: (a) not interfere with the physician-patient relationship; (b) not impose regulatory burdens that may discourage creativity and innovation in advancing device technology; (c) not change the character and mandate of existing Institutional Review Boards to unnecessarily burden members of the IRB's and clinical investigators; (d) not raise the cost of medical care and new medical technology without any concomitant benefit or additional safeguards being provided the patients; and (e) not interfere with patient records' confidentiality. (2) The AMA urges that existing mechanisms to assure ethical conduct be used to minimize burdensome reporting requirements and keep enforcement costs to a minimum for patients, health care providers, industry and the government.



AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 9  
(A-18)

Introduced by: Naiim Ali, MD; Gunjan Malhotra, MD; Sean Figy, MD; Amar Kelkar, MD; Tani Malhotra, MD; and Luke Selby, MD

Subject: Ownership and Sale of Medical Data

Referred to: Reference Committee

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Whereas, Several healthcare organizations (such as Truven Health, Merge Healthcare, and the National Health Service in the United Kingdom) have sold medical data to corporations (such as IBM and Google) to be used for commercial purposes<sup>1-2</sup>; and

Whereas, Use of medical data for research purposes, including non-identifiable data, requires oversight by an Institutional Review Board and often a rigorous informed consent process; and

Whereas, The sale of medical data is often done without consent of the patients from whom it was obtained, including instances of identifiable Protected Health Information<sup>3</sup>; and

Whereas, In the 2011 case of *Sorell vs. IMS Health Inc.*, the Supreme Court ruled that sale of physician prescribing data is protected under the First Amendment, but did not address the sale of patient-specific medical data<sup>4</sup>; and

Whereas, There are currently 21 states that deem that a hospital/physician is the owner of a patient's medical record, only one state (New Hampshire) that deems the patient to be the owner of his/her medical record, and 28 states in which ownership of medical records is currently undefined<sup>5</sup>; therefore be it

RESOLVED, that our American Medical Association (AMA) develop model legislation concerning ownership of medical records. (Directive to Take Action)

Fiscal Note: Minimal

**RELEVANT AMA AND RFS POLICY**

**Ownership of Patient Data D-315.976**

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<sup>1</sup> Steve Lohr, "IBM Buys Truven for \$2.6 Billion, Adding to Trove of Patient Data," *New York Times*, February 18, 2016, <https://www.nytimes.com/2016/02/19/technology/ibm-buys-truven-adding-to-growing-trove-of-patient-data-at-watson-health.html>.

<sup>2</sup> "Google DeepMind NHS app test broke UK privacy law," *BBC*, July 3, 2017, <http://www.bbc.com/news/technology-40483202>.

<sup>3</sup> Sam Thielman, "Your private medical data is for sale-and it's driving a business worth billions," *The Guardian*, January 10, 2017, <https://www.theguardian.com/technology/2017/jan/10/medical-data-multibillion-dollar-business-report-warns>.

<sup>4</sup> *Sorell v. IMS Health Inc.*, 564 U.S. 552 (2011), <https://www.law.cornell.edu/supct/pdf/10-779P.ZO>

<sup>5</sup> "Who Owns Medical Records: 50 State Comparison," *Health Information and the Law*, August 20, 2015, <http://www.healthinfolaw.org/comparative-analysis/who-owns-medical-records-50-state-comparison>.

Our AMA will undertake a study of the use and misuse of patient information by hospitals, corporations, insurance companies, or big pharma, including the impact on patient safety, quality of care, and access to care when a patient's data is withheld from his or her physician, with report back at the 2018 Annual Meeting.  
(Res. 019, A-17)

### **Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973**

1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles:
  - a. Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose.
  - b. All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules.
  - c. The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used.
  - d. Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data.
  - e. Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities.
  - f. Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed.
  - g. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his/her electronic medical records and claims data.
  - h. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations.
2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles:
  - a. The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information.
  - b. Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.
  - c. Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified.
  - d. Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed.

(CMS Rep. 6, I-06 Reaffirmed: BOT Rep. 17, A-13)

### **Work of the Task Force on the Release of Physician Data H-406.991**

Principles for the Public Release and Accurate Use of Physician Data

*The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles:*

1. Patient Privacy Safeguards
  - All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947).
  - Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983).
2. Data Accuracy and Security Safeguards
  - Effective safeguards are established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961).
  - Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961).
  - Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-406.996, H-450.947, H-450.961).

3. Transparency Requirements
  - When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961).
  - The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947).
  - The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961).
  - Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931).
4. Review and Appeal Requirements
  - Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961).
  - When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947).
5. Physician Profiling Requirements
  - The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-406.997, H-450.947, H-450.961).
  - Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors (450.951).
  - When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used (no current policy exists).
  - Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources so that the focus is on comparative physicians' patient utilization and not on the actual charges for services (no current policy exists).
  - Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes (no current policy exists).
6. Quality Measurement Requirements
  - The data are used to profile physicians based on quality of care provided - never on utilization of resources alone -- and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947).
  - Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961).
  - These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data (no current policy exists).
7. Patient Satisfaction Measurement Requirements
  - Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982).
  - Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms (no current policy exists).
  - As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication (no current policy exists).

(BOT Rep. 18, A-09 Reaffirmation A-10 Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10, and BOT Rep. 17, A-10 Reaffirmation I-10 Reaffirmed in lieu of Res. 808, I-10 Reaffirmed in lieu of Res. 824, I-10 Reaffirmation A-11 Reaffirmed: BOT Rep. 17, A-13 Reaffirmed: Res. 806, I-13)

### **Management of Medical Records 3.3.1**

Medical records serve important patient interests for present health care and future needs, as well as insurance, employment, and other purposes.

In keeping with the professional responsibility to safeguard the confidentiality of patients' personal information, physicians have an ethical obligation to manage medical records appropriately.

This obligation encompasses not only managing the records of current patients, but also retaining old records against possible future need, and providing copies or transferring records to a third party as requested by the patient or the patient's authorized representative when the physician leaves a practice, sells his or her practice, retires, or dies.

To manage medical records responsibly, physicians (or the individual responsible for the practice's medical records) should:

- (a) Ensure that the practice or institution has and enforces clear policy prohibiting access to patients' medical records by unauthorized staff.
- (b) Use medical considerations to determine how long to keep records, retaining information that another physician seeing the patient for the first time could reasonably be expected to need or want to know unless otherwise required by law, including:
  - (i) immunization records, which should be kept indefinitely;
  - (ii) records of significant health events or conditions and interventions that could be expected to have a bearing on the patient's future health care needs, such as records of chemotherapy.
- (c) Make the medical record available:
  - (iii) as requested or authorized by the patient (or the patient's authorized representative);
  - (iv) to the succeeding physician or other authorized person when the physician discontinues his or her practice (whether through departure, sale of the practice, retirement, or death);
  - (v) as otherwise required by law.
- (d) Never refuse to transfer the record on request by the patient or the patient's authorized representative, for any reason.
- (e) Charge a reasonable fee (if any) for the cost of transferring the record.
- (f) Appropriately store records not transferred to the patient's current physician.
- (g) Notify the patient about how to access the stored record and for how long the record will be available.
- (h) Ensure that records that are to be discarded are destroyed to protect confidentiality.

(Issued 2016)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 10  
(A-18)

Introduced by: Caitlin Farrell, DO, MPH

Subject: Coordinating Correctional and Community Healthcare

Referred to: Reference Committee

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Whereas, The United States has the highest rate of incarceration in the world<sup>1</sup> with an estimated 6,899,000 individuals held under the supervision of the correctional system at year end 2013<sup>2</sup>; and

Whereas, The incarcerated population has higher rates of many chronic diseases, including tuberculosis, HIV, hepatitis, asthma, mental health disorders, and substance abuse than the general public<sup>3</sup>; and

Whereas, The increased aging of the prison population will only increase the rates of chronic medical conditions<sup>4</sup>; and

Whereas, The health benefits gained through incarceration, such as food, housing, medication, and access to healthcare are lost upon release, as shown by the increased rate of all-cause mortality in the two weeks following release, as well as the increased rate of hospitalization among recently released inmates compared to the general public and the increased utilization of the emergency department and acute care settings<sup>5-6</sup>; and

Whereas, Health benefits have been demonstrated from the linkage of care from correctional institutions to community health clinics and resources, with poorer chronic health outcomes seen in those not linked to care on reentry compared to those linked to

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<sup>1</sup> Cloud DH, Parsons J, Delany-Brumsey A. Addressing mass incarceration: a clarion call for public health. *Am J Public Health*. 2014;104(3):389-391.

<sup>2</sup> Glaze LE, Kaeble D. Correctional populations in the United States, 2013. Bureau of Justice Statistics; 2014. Available at <http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5177>([www.bjs.gov](http://www.bjs.gov)). Accessed April 1, 2016.

<sup>3</sup> Marks JS and Turner N. The critical link between health care and jails. *Health Affairs*. 2014; 33(3): 443-447.

<sup>4</sup> Williams BA, Goodwin JS, Baillargeon J, Ahalt C, Walter LC. Addressing the aging crisis in U.S. criminal justice health care. *J Am Geriatr Soc*. 2012;60(6):1150-1156.

<sup>5</sup> Binswanger IA, Stern MF, Deyo RA, et al. Release from prison--a high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157-165.

<sup>6</sup> Frank JW, Linder JA, Becker WC, Fiellin DA, Wang, E. Increased hospital and emergency department utilization by individuals with recent criminal justice involvement: results of a national survey. *JGIM*. 29(9): 12256-33.

care, as well as decreased utilization of emergency department in those linked to community health care upon release<sup>7-8</sup>; therefore be it

RESOLVED, That our AMA support linkage of those incarcerated to community clinics upon release in order to accelerate linkage to primary care and improve health outcomes among this vulnerable patient population (Directive to Take Action); and be it further

RESOLVED, That our AMA support the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. (Directive to Take Action)

Fiscal Note: Minimal

#### **RELEVANT AMA AND RFS POLICY**

##### **Standards of Care for Inmates of Correctional Facilities H-430.997**

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

##### **Health Care While Incarcerated H-430.986**

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community. 2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system. 3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated. 4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid. 5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community. 6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism. 7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.

##### **Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization D-165.934**

Our AMA will study: (1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and (2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care.

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<sup>7</sup> Montague BT, Rosen DL, Sammartino C, et al. Systematic Assessment of Linkage to Care for Persons with HIV Released from Corrections Facilities Using Existing Datasets. *AIDS Patient Care STDS*. 2016;30(2):84-91.

<sup>8</sup> Montague BT, Rosen DL, Sammartino C, Costa M, Gutman R, Solomon L, Rich J. Systemic assessment of linkage to care of persons with HIV released from corrections facilities using existing databases. *AIDS Patient Care and STDs*. 2016: 30(2): 84-91.

## AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 11  
(A-18)

Introduced by: Hannah Steere, MD

Subject: A Study to Evaluate Barriers to Medical School Matriculation for Students with Disabilities

Referred to: Reference Committee

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Whereas, Section 504 of the Rehabilitation Act of 1973 states that individuals with disabilities should not “be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance<sup>1</sup>,” and

Whereas, The Association of American Medical Colleges (AAMC) published guidelines for technical standards (TS) in 1979 in response to Section 504 of the Rehabilitation Act of 1973<sup>2</sup> which called for “certain minimal technical standards for physicians that must be examined and enforced in the admissions process” and placed an emphasis on the MD degree encompassing “a broad undifferentiated degree attesting to the acquisition of general knowledge in all fields of medicine and the basic skills requisite for the practice of medicine”<sup>3, 4</sup>; and

Whereas, The above stated TS often emphasize sensorimotor over cognitive abilities, which therefore serve as a barrier for matriculation of students with disabilities<sup>5</sup> with research supporting this claim<sup>6</sup>; and

Whereas, The Americans with Disabilities Act of 1990 (ADA) prohibits institutions of higher education from discriminating against a qualified person on the basis of disability in admission or recruitment and requires entities that must comply with the law to make reasonable accommodations in order to afford an otherwise qualified applicant an equal opportunity to participate in institution’s programs<sup>7,8</sup>; and

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<sup>1</sup> Section 504 of the Rehabilitation Act of 1973 - Disability Rights Education & Defense Fund. <https://dredf.org/legal-advocacy/laws/section-504-of-the-rehabilitation-act-of-1973/>. Accessed January 21, 2018.

<sup>2</sup> Association of American Medical Colleges. Report of the Special Advisory Panel on Technical Standards for Medical School Admission. *Assoc Am Med Coll*. 1979;Washington.

<sup>3</sup> Association of American Medical Colleges. 4.

<sup>4</sup> Association of American Medical Colleges. 5.

<sup>5</sup> Wainapel, F. S. Unjustified Barriers for Medical School Applicants with Physical Disabilities - American Medical Association Journal of Ethics (formerly Virtual Mentor). *Virtual Mentor*. 2015;17(2):160. doi:10.1001/VIRTUALMENTOR.2015.17.2.PFOR2-1502.

<sup>6</sup> Zazove P, Case B, Moreland C, et al. U.S. Medical Schools’ Compliance With the Americans With Disabilities Act. *Acad Med*. 2016;91(7):979-986. doi:10.1097/ACM.0000000000001087.

<sup>7</sup> 42 U.S. Code § 12182 - Prohibition of discrimination by public accommodations | US Law | LII / Legal Information Institute. <https://www.law.cornell.edu/uscode/text/42/12182>. Accessed January 21, 2018.

<sup>8</sup> McKee M, Case B, Fausone M, Zazove P, Ouellette, Fetters and MD. Medical Schools’ Willingness to Accommodate Medical Students with Sensory and Physical Disabilities: Ethical Foundations of a Functional Challenge to “Organic” Technical Standards. *AMA J Ethic*. 2016;18(10):993-1002. doi:10.1001/journalofethics.2016.18.10.medu1-1610.

Whereas, Despite passage of the ADA, parity has not been realized for people with disabilities hopeful of starting a career in medicine as demonstrated by the fact that 19 percent of America's noninstitutionalized population has a disability<sup>9</sup> compared to 1 percent of medical students<sup>6</sup> and 2-10 percent of practicing physicians<sup>10</sup> although technical accommodations are widely available and used; and

Whereas, The majority of US medical schools' and residencies' TS do not explicitly support accommodating disabilities and furthermore "do not support provision of reasonable accommodations for students with disabilities as intended by the ADA" thus precluding individuals with disabilities from enrolling<sup>6</sup>; and

Whereas, TS uphold the largely unspoken standard of the "undifferentiated physician"—meaning all students graduating from medical school should be able to enter any medical specialty— though this is an unrealistic expectation for even students without disabilities and therefore rejecting students with disabilities based on limitations that would qualify them as unfit for certain specialties is an unjustified exclusion<sup>5,11</sup>; and

Whereas, The majority of US medical schools' and residencies' TS require students to demonstrate certain physical, cognitive, behavioral, and sensory abilities without assistance, therefore, highlighting the students' limitations<sup>6,8</sup> and have not been revised since their original form in 1979; therefore be it

RESOLVED, That our AMA and AMA-RFS partner with relevant stakeholders to increase outreach efforts directed at students with disabilities to support a culture of inclusion (Directive to Take Action); and be it further

RESOLVED, That our AMA and AMA-RFS work with relevant stakeholders to study and consider revision of technical standards for medical school admission. (Directive to Take Action)

Fiscal Note: Significant

#### RELEVANT AMA AND RFS POLICY

##### [Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992](#)

1. Our AMA supports legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability. 2. Our AMA opposes legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights. 3. Our AMA will develop educational tools and strategies to help physicians make their offices more accessible to persons with disabilities, consistent with the Americans With Disabilities Act as well as any applicable state laws.

##### [Support of Human Rights and Freedom H-65.965](#)

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender

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<sup>9</sup> Brault MW. Americans with Disabilities: 2010. 2012. [https://www.census.gov/newsroom/cspan/disability/20120726\\_cspan\\_disability\\_slides.pdf](https://www.census.gov/newsroom/cspan/disability/20120726_cspan_disability_slides.pdf). Accessed January 21, 2018.

<sup>10</sup> DeLisa JA, Thomas P. Physicians with disabilities and the physician workforce: a need to reassess our policies. *Am J Phys Med Rehabil*. 2005;84(1):5-11. <http://www.ncbi.nlm.nih.gov/pubmed/15632483>. Accessed January 21, 2018.

<sup>11</sup> Hartman DW, Hartman CW. Disabled students and medical school admissions. *Arch Phys Med Rehabil*. 1981;62(2):90-91. <http://www.ncbi.nlm.nih.gov/pubmed/6453567>. Accessed January 21, 2018.



identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

**9.5.4 Civil Rights & Medical Professionals**

Opportunities in medical society activities or membership, medical education and training, employment and remuneration, academic medicine and all other aspects of professional endeavors must not be denied to any physician or medical trainee because of race, color, religion, creed, ethnic affiliation, national origin, gender or gender identity, sexual orientation, age, family status, or disability or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.

([AMA Principles of Medical Ethics: IV](#))

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 12  
(A-18)

Introduced by: Amy Brown, MD

Subject: Support for Deferred Action for Childhood Arrivals (DACA) Medical Students and Physicians

Referred to: Reference Committee

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Whereas, The AMA has policy in place from 2016 to support medical students, residents, and physicians with Deferred Action for Childhood Arrivals (DACA) status and has already urged Congressional legislation to protect DACA recipients from deportation<sup>1</sup>; and

Whereas, Extensive coverage regarding the end of the DACA program from the White House demonstrates the importance on why the AMA should reaffirm their position on their support on this issue. The decision to end DACA does not recognize the contributions these recipients are providing to vital industries, including health care services. Ending this program could impact patients and further limit access to care; and

Whereas, This is the first year a large number of DACA recipients in medical school are graduating, with approximately 32 DACA medical students at Loyola University Medical School hopeful to start residency this July<sup>2</sup>. Estimates have shown the DACA initiative could help introduce 5,400 previously ineligible physicians into the US healthcare system in the coming decades that will further help address physician shortage<sup>3</sup>. Removing those with DACA status will create further shortages in underserved areas, as these physicians are more likely bilingual, with diverse cultural backgrounds, and will work in high-need communities<sup>3</sup>. Additionally, current DACA medical students and residents who are unable to complete their training will further waste medical education funding, provide undue financial hardship in loan repayments, and exacerbate the physician shortage<sup>4</sup>; therefore be it

RESOLVED, That our AMA reaffirm support for the Deferred Action for Childhood Arrivals (DACA) through a statement of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients (Directive to Take Action); and be it further

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<sup>1</sup> Kevin B. O'Reilly, "Dreamers' bolster physician workforce, should be allowed to stay," *AMA Wire*, September 6, 2017, <https://wire.ama-assn.org/ama-news/dreamers-bolster-physician-workforce-should-be-allowed-stay>.

<sup>2</sup> "DACA Repeal Puts Med Students in Murky Waters," *Chicago Tonight*, November 30, 2017, <https://chicagotonight.wttw.com/2017/11/30/daca-repeal-puts-med-students-murky-waters>

<sup>3</sup> "AMA Urges Congress to Take Action to Retain DACA Program Protections," September 5, 2017, <https://www.ama-assn.org/ama-urges-congress-take-action-retain-daca-program-protections>.

<sup>4</sup> Sarah Conway and Alex V. Hernandez, "Loyola's DACA medical students, largest group in the country, plagued with uncertainty," *Chicago Magazine*, January 29, 2018, <http://www.chicagotribune.com/voiceit/community/ct-hoy-loyola-s-daca-medical-students-largest-group-in-the-country-plagued-with-uncertainty-20180129-story.html>

RESOLVED, That the AMA continues supporting any legislation to protect DACA recipients.  
(Directive to Take Action)

Fiscal note: Minimal

**RELEVANT AMA AND RFS POLICY**

**Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages  
D-350.986**

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.  
(Res. 305, A-15 Appended: Late Res. 1001, I-16)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 13  
(A-18)

Introduced by: Scott H. Pasichow, MD, MPH and Zach Jarou, MD  
Subject: Scholarly Activity by Resident and Fellow Physicians  
Referred to: Reference Committee

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Whereas, The current requirements for scholarly activity for resident physicians vary between medical specialties and there is no uniform definition; and

Whereas, The current Accreditation Council for Graduate Medical Education (ACGME) common program requirement for scholarly activity are broad and non-specific only stating that residents “should participate in scholarly activity”; and

Whereas, There are many ways to teach an understanding of research methods, including literature review in the form of journal clubs, lectures, and small group discussions of research methods; and

Whereas, The completion of a research project only educates the participant on one form of research methodology; and

Whereas, Seventy-five percent of the physicians who complete residency do not go on to pursue careers in academic medicine<sup>1</sup> and thus gain little experience relevant to their future careers from the mandatory completion of a research project; and

Whereas, This percentage is not different when emergency medicine residency programs that require research are compared to programs that do not require research<sup>2</sup>; and

Whereas, Boyer’s model for scholarship was proposed for inclusion as part of the ACGME Common Program Requirements currently under revision, which emphasize that scholarly activity includes a wide variety of modalities, including discovery, integration, application, and teaching<sup>3</sup>; and

Whereas, Boyer’s model of scholarship application involves problem solving and putting into practice the discoveries from research<sup>3</sup>, not unlike the work done within national organizations such as the AMA; and

Whereas, Faculty in almost all medical and surgical specialties are allowed to use their national leadership experience within the AMA or specialty specific organizations as part of their

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<sup>1</sup> AAMC. “Report of Residents: Table C7. Full-Time Faculty-Appointment Status at U.S. Medical Schools for Residents Who Completed Residencies, by Specialty.” Published December 2017. Accessed April 9, 2018. Available at <https://www.aamc.org/data/484734/report-on-residents-2017-c7table.html>.

<sup>2</sup> Geyer B, Kaji A, Katz E, et.al. (2015) “A National Evaluation of the Scholarly Activity Requirement in Residency Programs: A Survey of Emergency Medicine Program Directors.” *Academic Emergency Medicine*. 22:11. 1337-44.

<sup>3</sup> Boyer E. (1990). *Scholarship Reconsidered: Priorities of the Professoriate*. Carnegie Foundation for the Advancement of Teaching. Accessed April 9, 2018. Available at <https://depts.washington.edu/gs630/Spring/Boyer.pdf>.

scholarly requirements<sup>4</sup> but trainees in those same specialties are not allowed to use that same national committee experience for the purpose of completing scholarly activity requirements<sup>5</sup>; and

Whereas, Proposed changes to the ACGME Common Program Requirements may still allow specialty-specific Review Committees to narrowly define scholarly activity as peer-reviewed publication only<sup>6</sup>; therefore be it

RESOLVED, That our AMA-RFS defines resident and fellow scholarly activity as any resident or fellow experience that involves the discovery, integration, application, or teaching of knowledge.(New RFS Policy); and be it further

RESOLVED, That our AMA work with partner organizations to ensure that scholarly activity requirements for residents, fellows, and faculty are not restricted to only peer-reviewed publications; and resident and fellow scholarly activity requirements can be fulfilled by the breadth of experiences permitted within faculty requirements (Directive to Take Action)

Fiscal Note: Minimal

## RELEVANT AMA AND RFS POLICY

### Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.

1. PURPOSE OF GRADUATE MEDICAL EDUCATION. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.
2. RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
3. EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.
4. SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The

<sup>4</sup> ACGME. "Specialty-specific References for DIOs: Faculty Scholarly Activity ACGME." September 2017. Internet. Accessed April 9, 2018. [https://www.acgme.org/Portals/0/PDFs/Specialty-specific%20Requirement%20Topics/DIO-Scholarly\\_Activity\\_Faculty.pdf](https://www.acgme.org/Portals/0/PDFs/Specialty-specific%20Requirement%20Topics/DIO-Scholarly_Activity_Faculty.pdf).

<sup>5</sup> ACGME. "Specialty-specific References for DIOs: Resident/Fellow Scholarly Activity ACGME." September 2017. Internet. Accessed April 9, 2018. [https://www.acgme.org/Portals/0/PDFs/Specialty-specific%20Requirement%20Topics/DIO-Scholarly\\_Activity\\_Resident-Fellow.pdf](https://www.acgme.org/Portals/0/PDFs/Specialty-specific%20Requirement%20Topics/DIO-Scholarly_Activity_Resident-Fellow.pdf).

<sup>6</sup> ACGME. "ACGME Common Program Requirements (Residency) Sections I-V." Published 6 February 2018. Accessed April 2018. Available at <http://www.acgme.org/Portals/0/PFAssets/ReviewandComment/CPR-Residency-2018-02-06-R&C.pdf>.

- continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
5. **FACULTY SCHOLARSHIP.** All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.
  6. **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
  7. **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.
  8. **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
  9. **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
  10. **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
  11. **THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION.** Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
  12. **SUPERVISION OF RESIDENT PHYSICIANS.** Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.
  13. **EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION.** Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.
  14. **GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING.** Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

15. VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

(CME Rep. 9, A-9)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 14  
(A-18)

Introduced by: Gunjan Malhotra, MD; Amar Kelkar, MD; Tani Malhotra, MD; Iva Golemi, MD; Iana Lesnikova, MD; Naiim Ali, MD; Luke Selby, MD; and Sean Figy, MD

Subject: Investigation into Residents, Fellows, and Physician Unions

Referred to: Reference Committee

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Whereas, Approximately 13% residents and fellows are part of formal unions<sup>1</sup>; and

Whereas, The ACGME introduced the Clinical Learning Environment Review (CLER) program in 2012 where teaching hospitals are visited every 18 months<sup>1</sup>; and

Whereas, These visits are meant to “gain knowledge about how clinical sites are supporting the training of residents and fellows in the areas of patient safety, health care quality, supervision, transitions in care, duty hours, fatigue management, and professionalism” according to the journal of graduate medical education<sup>1</sup>; and

Whereas, The intention of the external program is to allow residents to “freely, accurately, and honestly describe their teaching hospital environment in order to identify areas of improvement”<sup>1</sup>; and

Whereas, In 2009 the ACGME recommended an internal institutional form or other mechanism to give residents the opportunity to raise questions about and discuss educational and working conditions<sup>1</sup>; and

Whereas, Resident unions can provide a unified voice encouraging inter-specialty communication and engagement in hospital wide safety and quality improvement; and

Whereas, The Committee of Interns & Residents (the largest housestaff union composed of nearly 14,000 interns, residents, and fellows in California, Florida, Massachusetts, New York, New Mexico, and Washington D.C.) was formed in 1957 and aims to be “the national voice for physicians-in-training, uniting and empowering them to create a better and more just healthcare system for patients and healthcare workers and to improve training and quality of life for resident physicians, fellows, and their families”<sup>2</sup>; and

Whereas, There is still 87% of house staff not being represented by a union in this country; and

Whereas, Physicians as a whole could benefit from a union representing them and ensuring quality, safe, and evidenced based patient care; and

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<sup>1</sup> Flavio Casoy, MD and Joanne Suh, MD, “Patients lose when resident physicians are afraid to unionize,” *KevinMD.com*, January 5, 2014, <https://www.kevinmd.com/blog/2014/01/patients-lose-resident-physicians-afraid-unionize.html>.

<sup>2</sup> Committee of Interns and Residents, <https://www.cirseiu.org>.



Whereas, Insurance companies partnering with various entities (drug store chains/retail clinics, urgent care centers) and even corporations to provide care options to patients has not been proven to be evidenced based, safe, or cost effective<sup>3</sup>; and

Whereas, Physician membership, participation, and representation in organized medicine (including national organizations such as the American Medical Association and individual specialty societies) continues to be on the decline; and

Whereas, Physicians are increasingly becoming employed workers and 2016 was the year that marked the first time that physician practice owners are not the majority<sup>4</sup>; and

Whereas, Various mergers mean uncertainty for how physicians would be able to practice; and

Whereas, Patients are often being given an incorrect diagnosis and management; and

Whereas, This has caused physicians to become more divided by specialty and further marginalized due to the lack of unity and bargaining power; and

Whereas, Patient care choices are being dictated by insurance companies and coverage; and

Whereas, Physicians as a cohort benefit from the work done by physician medical societies even if they are not dues paying members leaving less resources for organized medical physician groups to operate on; and

Whereas, Many physicians cite the lack of time, lack of interest, and lack of agreement with organized physician medical groups as the reason for not joining organized medicine; and

Whereas, There are regional unions such as the Union of American Physicians and Dentists that have been established<sup>5,6</sup>; and

Whereas, A truly powerful physicians union will need to include all specialists<sup>7</sup>; and

Whereas, Other countries have successful models for a physician union<sup>8</sup>; and

Whereas, There is no national physician union representing physicians of all specialties in the U.S.; therefore be it

RESOLVED, That our AMA-RFS ask our AMA to support a change to internal policies and its stance on unions; and be it further

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<sup>3</sup> Reed Abelson and Julie Creswell, "The Disappearing Doctor: How Mega-Mergers Are Changing the Business of Medical Care," *The New York Times*, April 7, 2018, <https://www.nytimes.com/2018/04/07/health/health-care-mergers-doctors.html>.

<sup>4</sup> Brendan Murphy, "For first time, physician practice owners are not the majority," *AMA Wire*, May 31, 2017, <https://wire.ama-assn.org/practice-management/first-time-physician-practice-owners-are-not-majority>.

<sup>5</sup> Union of American Physicians and Dentists (UAPD), <https://www.uapd.com/all-doctors-need-a-union/>.

<sup>6</sup> Noam Scheiber, "Doctors Unionize to Resist the Medical Machine," *The New York Times*, January 9, 2016, <https://www.nytimes.com/2016/01/10/business/doctors-unionize-to-resist-the-medical-machine.html>.

<sup>7</sup> Margalit Gur-Arie, "Physicians must unionize. Here's why.," *KevinMD.com*, January 12, 2015, <https://www.kevinmd.com/blog/2015/01/physicians-must-unionize-heres.html>.

<sup>8</sup> Yngre Laeger, <https://www.laeger.dk/information-in-english-yngre-laege>.

RESOLVED, That the AMA-RFS support and ask our AMA to support a national house-staff union to represent all interns, residents and fellows; and be it further

RESOLVED, That our AMA investigate, with internal resources, the possibility, feasibility, and advisability of the AMA in organizing and running a physician union that prohibits actions that affect patient care while collectively representing all physicians as a true union and present a report on its findings no later than the AMA Annual Meeting 2019; and be it further

RESOLVED, That our AMA-RFS forward this resolution to the AMA House of Delegates at the 2018 Interim Meeting.

Fiscal Note: Significant

**Relevant AMA and RFS Policy:**

**Collective Negotiations by Residents 293.006R**

That our AMA ask its representatives to the ACGME to continue their diligence in supporting inclusion of the following AMA proposed amended language into Section 1,B,3,e(1) of ACGME's Institutional Requirements:

Section 1,B,3,e(1) Provision of an organization system for communication and resolution of resident concerns on all issues pertaining to resident educational programs, patient care and resident well being. Institutions must allow resident physicians the ability to form a resident organization and use it or other forums to facilitate regular assessment of resident concerns; (2) that the AMA approve a nationwide program offering supporting materials and telephone and on-site assistance to groups of residents seeking to form independent housestaff organizations advocating no actions resulting in withholding care; and (3) that the AMA study the potential affects on future resident demand for housestaff associations or unionizations should the NLRB rule that all residents are subject to legal protections under the NLRA and make recommendations as to ways in which the AMA can appropriately address those demands.

(Report F, A-98)

**Resident Physicians, Unions, and Organized Labor H-383.998**

Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.

(CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: Speakers Rep. 01, A-17)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 16  
(A-18)

Introduced by: Gunjan Malhotra, MD; Amar Kelkar, MD; Tani Malhotra, MD; Luke Selby, MD; Naiim Ali, MD; and Sean Figy, MD

Subject: Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogram

Referred to: Reference Committee

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Whereas, “Dense breast” tissue makes it harder to identify cancer on a mammogram, especially if there are no calcifications present within the cancer<sup>1</sup>; and

Whereas, Patients with “dense breast” tissue are also associated with an increased risk of breast cancer (i.e., the risk is estimated to be four times greater for women with extremely dense breasts versus women with fatty breasts)<sup>1</sup>; and

Whereas, A “negative” screening mammography result does not reliably rule out cancer in women with dense breasts<sup>1</sup>; and

Whereas, These women with “dense breast” tissue often have higher stage cancers upon detection due to the fact that they are not discovered until they are larger and symptomatic<sup>1</sup>; and

Whereas, Ultrasound and MRI have been shown to reduce interval cancers in women with “dense breasts”<sup>1</sup>; and

Whereas, Approximately 30 states have adopted laws requiring notification to patients with “dense breasts”<sup>2</sup>; and

Whereas, The decision to pursue additional screening should be a result of the conversation between individual patients and their physician-led health care team<sup>1</sup>; and

Whereas, Insurance companies are not required to pay for additional screening<sup>3</sup>; therefore be it

RESOLVED, That our AMA support insurance coverage for supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician (Directive to Take Action); and be it further

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<sup>1</sup> Berg WA. Supplemental Breast Cancer Screening in Women with Dense Breasts Should be Offered with Simultaneous Collection of Outcomes Data. *Annals of internal medicine*. 2016;164(4):299-300. doi:10.7326/M15-2977.

<sup>2</sup> Breast Density Notification Laws by State — Interactive Map. Available at <http://www.diagnosticimaging.com/breast-imaging/breast-density-notification-laws-state--interactive-map>.

<sup>3</sup> Dense Breast Info. Available at <http://densebreast-info.org/legislation.aspx>.

RESOLVED, That our AMA advocate for insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician. (Directive to Take Action)

Fiscal Note: Moderate

#### **RELEVANT AMA AND RFS POLICY**

##### **[Screening Mammography H-525.993](#)**

Our AMA: a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer. b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis. c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations. d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available. e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography. f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient. g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors for breast cancer, so that recommendations for screening will be appropriate. h. supports insurance coverage for screening mammography. i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy. j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 17  
(A-18)

Introduced by: Jason D. Hall, MD, JD; Luke V. Selby, MD, MS;  
Grayson W. Armstrong, MD, MPH; Sean Figy, MD;  
and Laura Halpin, MD, PhD

Subject: Internal Operating Procedures Revision

Referred to: Reference Committee

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- 1 Whereas, Our AMA-RFS Internal Operating Procedures (IOPs) have undergone many  
2 piecemeal amendments, most recently in April 2016; and  
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4 Whereas, Our AMA-RFS has proposed modernizing the IOPs to eliminate redundancy, internal  
5 conflict, and irrelevant provisions; and  
6  
7 Whereas, Our AMA-RFS has been unable to complete modernization of the IOPs; and  
8  
9 Whereas, Our AMA-RFS has no formal process to provide for review and revision of the IOPs;  
10 therefore be it  
11  
12 RESOLVED, That our AMA-RFS will form an ad hoc committee (Committee) broadly  
13 representing the membership of the Assembly for the purpose of reviewing and revising the  
14 AMA-RFS IOPs; and be it further  
15  
16 RESOLVED, That our AMA-RFS will receive from the Governing Council at I-18 a  
17 comprehensive draft report from the Committee reviewing the IOPs and detailing proposed  
18 revisions thereto; and be it further  
19  
20 RESOLVED, That the Governing Council will make the draft report available electronically to the  
21 membership of the AMA-RFS Assembly at least 42 days prior to I-18; and be it further  
22  
23 RESOLVED, That our AMA-RFS will dedicate time during the I-18 business meeting for  
24 comment on the draft report and the proposed revisions to the IOPs; and be it further  
25  
26 RESOLVED, That our AMA-RFS will receive from the Governing Council at A-19 a final report  
27 from the Committee detailing final proposed revisions to the IOPs based on comment obtained  
28 at I-18; and be it further  
29  
30 RESOLVED, That the Governing Council will make the final report available electronically to the  
31 membership of the AMA-RFS Assembly at least 2 months prior to A-19; and be it further  
32  
33 RESOLVED, That our AMA-RFS Speaker call for a vote either to approve or to refer the final  
34 report of the Governing Council in the normal course of business at A-19, unless such order of  
35 business be modified by the will of the Assembly; and be it further  
36  
37 RESOLVED, That our AMA-RFS Speaker may call for a vote to approve or refer individual  
38 bylaws or groups of bylaws using the discretion afforded by the Rules of Parliamentary

- 1 Procedure to reflect the will of the RFS Assembly and to maintain internal consistency in the  
2 approved bylaws; and be it further  
3  
4 RESOLVED, That the Governing Council will return with a revised report from the Committee  
5 addressing all referred items at each subsequent meeting during which a vote will be taken to  
6 either approve or refer the report as a whole or in part; and be it further  
7  
8 RESOLVED, That our AMA-RFS follow normal operating procedure by submitting revised IOPs  
9 to the AMA for approval only after the RFS Assembly has approved a complete set of IOP  
10 revisions through this process; and be it further  
11  
12 RESOLVED, That our AMA-RFS reconvene the Committee every 10 years to modify, as  
13 needed, our IOPs except as otherwise provided in future revisions of the IOPs.

Fiscal Note: Minimal

**RELEVANT AMA AND RFS POLICY**

**Resolution and Report Submission Deadlines 580.003R**

The following IOP Changes were adopted: Resolutions or Reports that are submitted after the 42-day deadline but 7 days prior to the Assembly meeting are considered Late Resolutions; Resolutions submitted within 7 days of the meeting or after the meeting has been called to order are considered Emergency Resolutions.  
(Report E, A-09)