DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2018 Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-18)

Report of Reference Committee C

Sherri S. Baker, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 2 – Update on Maintenance of Certification and Osteopathic Continuous Certification
2. Council on Medical Education Report 4 – Evaluation of Clinical Documentation Training
3. Resolution 319 – All Payer Graduate Medical Education Funding
4. Resolution 320 - Young Physician Involvement in Maintenance of Certification

RECOMMENDED FOR ADOPTION AS AMENDED

5. Council on Medical Education Report 1 – Council on Medical Education Sunset Review of 2008 House Policies
6. Council on Medical Education Report 3 – Expanding UME Without Concurrent GME Expansion
7. Council on Medical Education Report 6 – Mental Health Disclosures on Physician Licensing Applications
8. Resolution 301 – Protecting Medical Trainees from Hazardous Exposure
9. Resolution 302 – For-Profit Medical Schools or Colleges
10. Resolution 303 – Fellowship Start Date
11. Resolution 304 – Persons With Intellectual and Developmental Disabilities Designated as a Medically Underserved Population
12. Resolution 306 – Sex and Gender Based Medicine
13. Resolution 311 – Opioid Education for New Trainees
14. Resolution 312 – Suicide Awareness Training
15. Resolution 313 – Financial Literacy for Medical Students and Residents
16. Resolution 315 – Peer-Facilitated Intergroup Dialogue
17. Resolution 318 – AMA Convene Stakeholders to Transition USMLE to Pass / Fail Scoring

RECOMMENDED FOR REFERRAL

18. Resolution 305 – Standardization of Medical Licensing Time Limits Across States
19. Resolution 307 – Healthcare Finance in the Medical School Curriculum
20. Resolution 314 – Board Certification Changes Impact Access to Addiction Medicine Specialists
21. Resolution 316 – End "Part 4 Improvement in Medical Practice" Requirement for ABMS MOC®
22. Resolution 317 – Emerging Technologies (Robotics and AI) in Medical School Education

RECOMMENDED FOR NOT ADOPTION

23. Resolution 309 – Foreign Trained IMGs Competency-Based Specialty Exam Without U.S. Residency

Note: The following items were withdrawn and not considered.

Resolution 308 – Foreign Trained IMGs Obtaining a U.S. License Without U.S. Residency

Resolution 310 – U.S. Institutions With Restricted Medical License

(1) COUNCIL ON MEDICAL EDUCATION REPORT 2 - UPDATE ON MAINTENANCE OF CERTIFICATION AND OSTEOPATHIC CONTINUOUS CERTIFICATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: The recommendations in Council on Medical Education Report 2 adopted and the remainder of the report filed.

Council on Medical Education Report 2 asks 1) That our American Medical Association (AMA) continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so; and 2) That our AMA, through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission.

Your Reference Committee heard testimony in support of the Council's comprehensive annual report to the HOD. During testimony, it was noted that the Council's efforts in working with the American Board of Medical Specialties and its member boards are improving the process for diplomates in many specialties by, for example, replacing the high-stakes examination with more relevant, less onerous, and cost efficient exams. The ABMS and the member boards have established a "Continuing Board Certification: Vision for the Future Commission" to modernize continuing board certification and engage physicians, the public, and key stakeholders in a collaborative process. The AMA, through the Council on Medical Education, continues to be actively engaged in following and contributing to the work of the Commission and, as noted in the report, the Council jointly convened a conference in March with the ABMS and the member boards to develop recommendations for the Commission. Although it was suggested that the recommendations in Resolution 318-A-17, "Oppose Direct to Consumer Advertising of the ABMS MOC Product," be further studied, your Reference Committee felt that CME Report 2 thoroughly explored and addressed this issue based on the testimony. Therefore, your Reference Committee recommends that Council on Medical Education Report 2 be adopted.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 4 - EVALUATION OF CLINICAL DOCUMENTATION TRAINING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 4 be adopted and the remainder of the report be filed.

HOD ACTION: The recommendations in Council on Medical Education Report 4 adopted and the remainder of the report filed.

Council on Medical Education Report 4 asks 1) That Policy D-295.314, "Study of Current Trends in Clinical Documentation," be rescinded, as having been fulfilled by this report; 2) That our American Medical Association (AMA) encourage medical schools and residency programs to design clinical documentation and electronic health records (EHR) training that provides evaluative feedback regarding the value and effectiveness of the training, and, where necessary, make modifications to improve the training; 3) That our AMA encourage medical schools and residency programs to provide clinical documentation and EHR training that can be evaluated and demonstrated as useful in clinical practice; and 4) That our AMA encourage medical schools and residency programs to provide EHR professional development resources for faculty to assure appropriate modeling of EHR use during physician/patient interactions.

Your Reference Committee heard unanimous support for this report's recommendations, which seek to address the need for medical school graduates to be fully prepared for clinical note taking in an electronic health record in order to improve patient care, reduce the risk of physician burnout, and ensure appropriate reimbursement. Testimony also praised the report for its acknowledgment that faculty likewise require training in this area, and for identifying specific training methods that have been proven to be effective. Therefore, your Reference Committee recommends that Council on Medical Education Report 4 be adopted.

(3) RESOLUTION 319 – ALL PAYER GRADUATE MEDICAL EDUCATION FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 319 be adopted.

HOD ACTION: Resolution 319 adopted.

Resolution 319 asks that our AMA Board of Trustees investigate the status of implementation of AMA Policies D-305.973, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs" and D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education" and report back to the

House of Delegates with proposed measures to resolve the problems of underfunding, inadequate number of residencies and geographic maldistribution of residencies.

Your Reference Committee heard almost unanimous support for Resolution 319. Testimony noted that this topic remains pressing for medical students and residents, and that this policy directive will ensure that a sense of urgency remains at the forefront of our AMA's advocacy efforts. Additional testimony elicited potential workforce considerations, which are of growing importance. It was observed that the AMA has extensive policy related to this issue (D-305.967), which already calls for reports to the HOD as changes to the GME financing system occur. Your Reference Committee concurs that this policy is relevant; therefore, additional calls for review of this important subject are timely and relevant. For these reasons, your Reference Committee recommends that Resolution 319 be adopted.

(4) RESOLUTION 320 - YOUNG PHYSICIAN INVOLVEMENT IN MAINTENANCE OF CERTIFICATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 320 be adopted.

HOD ACTION: Resolution 320 adopted.

Resolution 320 asks that our AMA submit commentary to the American Board of Medical Specialties (AMBS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards, and that our AMA work with American Board of Medical Specialties (AMBS) and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards.

Your Reference Committee heard unanimous testimony in support of this resolution. The Council on Medical Education has begun discussions with the ABMS and its member boards to make them aware of the discrepancies that currently exist on the composition of the boards. At least two medical boards restrict participation until diplomates have had at least 10 years of certification or are of “mature age.” The Council will also be addressing the 30-day or more time commitment to serve on member boards, and plans to investigate the current degree of young physician involvement/representation on the boards. Therefore, your Reference Committee recommends that Resolution 320 be adopted.

(5) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COUNCIL ON MEDICAL EDUCATION SUNSET REVIEW OF 2008 HOUSE POLICIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 1 be amended by addition, to read as follows:

Council on Medical Education Report 1 recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated, with the exception of H-200.975, "Availability, Distribution and Need for Family Physicians," which should be retained, and H-295.993, "Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs," which should be amended by addition and deletion, to read as follows:

H-295.993, "Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs"

Our AMA: (1) recognizes the need for ~~(a)~~ appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state ~~existing medical society impaired~~ physician health programs~~;~~ and ~~(b) these~~ wellness and other programs ~~to include activities~~ to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services~~medical school impairment treatment programs and that schools ensure that these services are provided confidentially~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Medical Education Report 1 be adopted as amended and the remainder of the report be filed.

HOD ACTION: The recommendation in Council on Medical Education Report 1 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 1 recommends that the House of Delegates policies listed in the appendix to the report be acted upon in the manner indicated and the remainder of this report be filed.

Your Reference Committee heard testimony that H-200.975, “Availability, Distribution and Need for Family Physicians,” should be retained, to avoid the removal from policy of the phrase "financing measures for medical education and research," which is important to primary care. In addition, testimony was heard that our AMA needs to have mechanisms in place to allow for state physician health programs to enroll non-licensed medical students and residents in their monitoring processes. Therefore, your Reference Committee recommends that Council on Medical Education Report 1 be adopted as amended.

(6) COUNCIL ON MEDICAL EDUCATION REPORT 3 - EXPANDING UME WITHOUT CONCURRENT GME EXPANSION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Medical Education Report 3 be amended by addition and deletion, to read as follows:

3) That our AMA ~~encourage~~ strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 3 be adopted as amended and the remainder of the report be filed.

HOD ACTION: The recommendations in Council on Medical Education Report 3 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 3 asks 1) That Policy D-305.967 (31), “The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education,” be rescinded, as having been fulfilled by this report; 2) That our American Medical Association (AMA) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; 3) That our AMA encourage legislators,

private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates; and 4) That our AMA encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

Your Reference Committee heard both online and in-person testimony in strong support of Council on Medical Education Report 3. Speakers noted that increased competition for limited GME training slots could deter well-qualified applicants from entering training due to a fear of accruing substantial medical school debt without the guarantee of placement in the physician workforce. Testimony also supported the development of GME funding sources beyond Medicare, and noted the importance of enhanced data collection related to Match rates. All testimony was in near-agreement that this is an important topic that bears ongoing surveillance. An amendment was proposed to Recommendation 3, which strengthens the language related to our AMA's proposed advocacy work and considers the makeup of the U.S. physician workforce. Therefore, your Reference Committee recommends that the recommendations of Council on Medical Education Report 3 be adopted as amended.

(7) COUNCIL ON MEDICAL EDUCATION REPORT 6 - MENTAL HEALTH DISCLOSURES ON PHYSICIAN LICENSING APPLICATIONS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education Report 6 be amended by addition and deletion, to read as follows:

1. That our American Medical Association (AMA) amend Policy H-275.970, Part 5, "Licensure Confidentiality," by addition and deletion to read as follows:
The AMA (5) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is ~~currently~~ suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~ (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 2 in Council on Medical Education Report 6 be amended by addition, to read as follows:

2. That our AMA encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards ~~American Psychiatric Association~~ that reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)." (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Education Report 6 be adopted as amended and the remainder of the report be filed.

HOD ACTION: The recommendations in Council on Medical Education Report 6 adopted as amended and the remainder of the report filed.

Council on Medical Education Report 6 asks 1) That our American Medical Association (AMA) amend Policy H-275.970, Part 5, "Licensure Confidentiality," by addition and deletion to read as follows:

The AMA (5) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is currently suffering from any condition that impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~; and 2) That our AMA encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the American Psychiatric Association that reads, "Are you currently suffering from any condition that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."

Your Reference Committee heard unanimous online and in-person testimony in support of this report. Many agreed that reforms in licensure applications are needed to prevent the stigma endured by physicians seeking care for either physical or mental health issues, partly due to concerns of career and licensure implications. In addition to

concerns related to stigma, deterred or deferred care seeking, the lack of understanding of impairment vs. illness was also noted. It was suggested that the recommendations in the report be further amended to recognize that licensure application questions should focus on the presence or absence of current impairments that are meaningful in the context of the physician's practice, competence, and ability to provide safe medical treatment to patients. It was also suggested that licensure applications not seek information about impairment that may have occurred in the distant past and that state medical boards should limit the timeframe for such historical questions to two years or less, though a focus on the presence or absence of current impairment is preferred. Finally, an amendment was provided to Recommendation 2 to reference recommended language from Federation of State Medical Boards' policy. Therefore, your Reference Committee recommends that Council on Medical Education Report 6 be adopted as amended.

(8) RESOLUTION 301 - PROTECTING MEDICAL TRAINEES FROM HAZARDOUS EXPOSURE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 301 be amended by addition and deletion, to read as follows:

2) That our AMA encourage the Accreditation Council for Graduate Medical Education, ~~and~~ Liaison Committee on Medical Education, and Committee on Osteopathic College Accreditation to create standards that allow all students and trainees to voluntarily avoid exposure to hazardous/biohazard materials without negatively impacting their standing in school or training programs. (New HOD Policy)~~; and be it further~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 301 be amended by deletion, to read as follows:

~~3) That our AMA support and encourage the specific option for students or trainees to be able to excuse themselves from exposure to Methylmethacrylate if they are or think they may be pregnant without negatively impacting their standing in their school or training programs (New HOD Policy); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 301 be referred.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 301 be adopted as amended.

HOD ACTION: Resolution 301 referred.

Resolution 301 asks 1) that our AMA call for the mandatory education of students, residents, physicians and surgeons on the deleterious effects of exposure to hazardous materials; 2) that our AMA encourage the Accreditation Council for Graduate Medical Education and Liaison Committee on Medical Education to create standards that allow students and trainees to voluntarily avoid exposure to hazardous/biohazard materials without negatively impacting their standing in school or training programs; 3) that our AMA support and encourage the specific option for students or trainees to be able to excuse themselves from exposure to Methylmethacrylate if they are or think they may be pregnant without negatively impacting their standing in their school or training programs; and 4) that our AMA support and encourage constant updating of the protection of medical trainees, physicians and surgeons from exposure to hazardous materials during the course of their medical school training and practice, using standards published by the Occupational Safety and Health Administration; the National Institute for Occupational Safety and Health and other Centers for Disease Control and Prevention agencies; the College of American Pathologists; and the American College of Radiology, as well as other relevant resources available for health workers.

Your Reference Committee heard online and in-person testimony in strong support of Resolution 301-A-18, with speakers noting the importance of protecting trainees and colleagues. Weight also was given to the argument that measures of self-protection should not negatively impact one's standing in a training program or workplace. Testimony suggested that the scope of the resolution should be broadened beyond medical students and residents to include physicians and surgeons, and a recommendation was made to widen the scope of the action beyond Methylmethacrylate, specifically to incorporate hazardous materials more generally. However, testimony also was offered stressing the inconclusive findings related to the hazardous, or non-hazardous, nature of various materials. It was also noted that this impacts both men and women. Your Reference Committee agrees with these recommendations. Therefore, your Reference Committee recommends that Resolution 301 be adopted as amended and the final resolve be referred for further study as to what constitutes a hazardous material.

(9) RESOLUTION 302 - FOR-PROFIT MEDICAL SCHOOLS OR COLLEGES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 302 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (1) attrition rate of students, (2) financial burden of non-graduates versus graduates, (3) success of graduates in obtaining a residency position, and (4) level of support for graduate medical education, and report back at the 2019 Annual Meeting. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 302 be adopted as amended.

HOD ACTION: Resolution 302 adopted as amended.

Resolution 302 asks that our AMA study issues related to medical education programs offered at for-profit medical schools and report back at the 2019 Annual Meeting.

Your Reference Committee heard testimony in favor of this item, with the caveat that the scope of the word "issues" was unclear; accordingly, revisions were proferred by the author of the resolution to elucidate the issues the proposed study should encompass. Therefore, your Reference Committee recommends that Resolution 302 be adopted as amended.

(10) RESOLUTION 303 - FELLOWSHIP START DATE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 303 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with relevant stakeholders to study the impact of delayed fellowship start dates after July 1 to ~~survey physicians who have experienced a fellowship start date of August 1st to further~~ evaluate the benefits and drawbacks for all interested parties~~from this transition~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 303 be adopted as amended.

HOD ACTION: Resolution 303 adopted as amended.

Resolution 303 asks that our AMA survey physicians who have experienced a fellowship start date of August 1st to further evaluate the benefits and drawbacks from this transition.

Your Reference Committee heard largely supportive testimony regarding this resolution. Testimony noted the lack of data regarding the impact of different start dates on trainees, programs, and patients. Other testimony alluded to likely universal interest on the part of program directors in data related to this issue. However, other testimony recognized that a survey as outlined in the resolution would lack a comparison group, rendering results less meaningful. Also, the observation was made that our AMA has no purview over the start dates of any fellowship programs, and those organizations that do possess this authority likely would be better suited to study this topic further. Your Reference Committee concurs, however, that our AMA would be a natural partner in this type of endeavor, and therefore recommends that Resolution 303 be adopted as amended.

(11) RESOLUTION 304 - PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES DESIGNATED AS A MEDICALLY UNDERSERVED POPULATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 304 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Policy H-90.968 be reaffirmed in lieu of the second Resolve of Resolution 304.

HOD ACTION: The first Resolve of Resolution 304 adopted, and Policy H-90.968 reaffirmed in lieu of the second Resolve of Resolution 304.

Resolution 304 asks 1) that our AMA advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population, and 2) that our AMA encourage medical schools and graduate medical education programs to include IDD-related competencies and objectives in their curricula.

Your Reference Committee heard online and in-person testimony in support of Resolve 1 of Resolution 304, noting that individuals with intellectual and developmental disabilities represent a unique high-risk population that may require additional health resources beyond those which are readily available to them. A recommendation was made, however, to reaffirm AMA Policy H-90.968, “Medical Care of Persons with Developmental Disabilities,” in lieu of Resolve 2, as existing policy (in particular, sections 4, 7, and 8) already calls for education on this important topic. Therefore, your Reference Committee recommends that the first Resolve of Resolution 304 be adopted and the second Resolve be reaffirmed.

Policy recommended for reaffirmation:

H-90.968, “Medical Care of Persons with Developmental Disabilities”
4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.

(12) RESOLUTION 306 - SEX AND GENDER BASED MEDICINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 306 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work collaboratively with the Liaison Committee on Medical Education and other interested organizations for the inclusion of sex- and gender-based differences within the ~~mandated~~ curricular content for medical school accreditation.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 306 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 306 be changed, to read as follows:

SEX- AND GENDER-BASED MEDICINE

HOD ACTION: Resolution 306 adopted as amended with a change in title.

Resolution 306 asks that our AMA work collaboratively with the Liaison Committee on Medical Education for the inclusion of sex-based differences within the mandated curricular content for medical school accreditation.

Your Reference Committee heard unanimous testimony in support of this resolution. This resolution is primarily calling for our AMA to work collaboratively with the Liaison Committee on Medical Education, but it was felt that other organizations may also be interested in working with our AMA on this issue. AMA policy supports the inclusion of women's health issues throughout the basic science and clinical phases of the curriculum. It was also suggested that medical schools should provide opportunities for medical students to learn to recognize and appropriately address sex differences in organ systems during the diagnosis and treatment of patients. Because there are gaps in medical education and training on this topic, it is reasonable to recommend that this topic be included in medical school curricula. A minor amendment was recommended to recognize that our AMA does not support mandating medical school curricula. Therefore, your Reference Committee recommends that Resolution 306 be adopted as amended.

(13) RESOLUTION 311 - OPIOID EDUCATION FOR NEW TRAINEES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 311 be amended by addition, to read as follows:

RESOLVED, That our American Medical Association work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to establish opioid education guidelines for medical students, physicians in training, and practicing physicians.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 311 be adopted as amended.

HOD ACTION: Resolution 311 adopted as amended:

RESOLVED, That our American Medical Association work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for Graduate Medical Education, and other interested professional organizations to ~~establish~~ develop opioid education ~~guidelines~~ resources for medical students, physicians in training, and practicing physicians.

Title of Resolution 311 changed to:

OPIOID EDUCATION FOR NEW TRAINEES AND PRACTICING PHYSICIANS

Resolution 311 asks that our AMA work in conjunction with the Accreditation Council for Graduate Medical Education to establish opioid education guidelines for physicians in training.

Your Reference Committee heard online and in-person testimony in strong support of this resolution. Although our AMA does not typically support curricular mandates, it was felt that this resolution does not represent a mandate as it touches on a topic (opioid prescribing) that is covered in different parts of undergraduate medical education (physiology, pharmacology, the clinical clerkships) and graduate medical education. It was noted that 64,000 people died from opioid overdoses in 2016, and nearly half of all opioid-related deaths involved prescription opioids. However, the level of education on opioids does not seem to be consistent, opioid prescribing practices vary with different regions of practice, and even those who practiced in the same hospital and same specialty have differences in opioid prescription practices. Thus, there was unanimous support for educational guidelines regarding the practice of prescribing opioid medications. A minor amendment was recommended to expand the organizations that should be involved in establishing opioid education guidelines and to extend the education guidelines across the continuum of medical education. Therefore, your Reference Committee recommends that Resolution 311 be adopted as amended.

(14) RESOLUTION 312 - SUICIDE AWARENESS TRAINING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 312 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association engage with the ~~Liaison Committee on Medical Education~~ appropriate organizations to ~~encourage the inclusion of formalized~~ facilitate the development of educational resources and training related to suicide ~~awareness~~ risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals ~~training~~, using an evidence-based multidisciplinary approach~~, in the curriculum of all accredited medical schools~~. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 312 be adopted as amended.

HOD ACTION: Resolution 312 adopted as amended.

Resolution 312 asks that our AMA engage with the Liaison Committee on Medical Education to encourage the inclusion of formalized suicide awareness training, using an evidence-based multidisciplinary approach, in the curriculum of all accredited medical schools.

Your Reference Committee heard universal support for this resolution both online and in person. Testimony strongly encouraged our AMA to take the lead in this critical area, noting that suicide risk can impact patients in addition to physicians, trainees, and other health care professionals. Therefore, your Reference Committee recommends that Resolution 312 be adopted as amended.

(15) RESOLUTION 313 - FINANCIAL LITERACY FOR MEDICAL STUDENTS AND RESIDENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 313 be amended by addition, to read as follows:
RESOLVED, That our American Medical Association amend policy D-295.316 by addition as follows:

Management and Leadership for Physicians D-295.316

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.

2. Our AMA will work with key stakeholders to advocate for collaborative programs ~~between~~ among medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.

3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving personal and professional financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early

in medical training to promote the development of leadership and personal and professional financial literacy capabilities.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 313 be adopted as amended.

HOD ACTION: Resolution 313 adopted as amended.

Resolution 313 asks that our AMA amend Policy D-295.316 by addition to read as follows:

Management and Leadership for Physicians D-295.316
1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.
2. Our AMA will work with key stakeholders to advocate for collaborative programs between medical schools, residency programs, and related schools of business and management to better prepare physicians for administrative, financial and leadership responsibilities in medical management.
3. Our AMA: (a) will advocate for and support the creation of leadership programs and curricula that emphasize experiential and active learning models to include knowledge, skills and management techniques integral to achieving financial literacy and leading interprofessional team care, in the spirit of the AMA's Accelerating Change in Medical Education initiative; and (b) will advocate with the Liaison Committee for Medical Education, Association of American Medical Colleges and other governing bodies responsible for the education of future physicians to implement programs early in medical training to promote the development of leadership and financial literacy capabilities.

Your Reference Committee heard testimony that was generally in support of this resolution, which modifies existing policy. Financial literacy is viewed as critical to address the challenge of medical student debt and ensure that medical students are able to make informed financial and career decisions. There was a request to clarify whether the financial literacy initially proposed was personal or professional in nature; language to that effect has been added to address this concern. Therefore, your Reference Committee recommends that Resolution 313 be adopted as amended.

(16) RESOLUTION 315 - PEER-FACILITATED INTERGROUP DIALOGUE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 315 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~work with the AMA Council on Medical Education and Academic Physician Section to~~ encourage ~~the Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to include~~ the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 315 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 315 be changed, to read as follows:

PEER-FACILITATED INTERGROUP DIALOGUE TO PROMOTE CULTURAL COMPETENCE AND HUMILITY

HOD ACTION: Resolution 315 adopted as amended with a change in title.

Resolution 315 asks that our AMA work with the AMA Council on Medical Education and Academic Physician Section to encourage the Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to include peer-facilitated intergroup dialogue in medical education programs nationwide.

Your Reference Committee heard limited but supportive testimony on this resolution. Testimony noted that peer-facilitated dialogue can be an important strategy to address cultural proficiency and cultural humility in medical education, although additional testimony reflected that other types of learning—such as problem-based learning sessions—can also be a part of a larger toolkit used to address this important issue. Your Reference Committee believes that peer-facilitated intergroup dialogue can be a

valuable addition to the strategies educational leaders can use to engage learners in cultural humility. Therefore, your Reference Committee recommends that Resolution 315 be adopted as amended.

(17) RESOLUTION 318 - AMA CONVENE STAKEHOLDERS TO TRANSITION USMLE TO PASS / FAIL SCORING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 318 be amended by addition, to read as follows:

3. Our AMA will ~~work with~~ co-convene the appropriate stakeholders to study ~~alternate means of~~ possible mechanisms for transitioning scoring of the USMLE and COMLEX exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE and COMLEX scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 318 be adopted as amended.

HOD ACTION: Resolution 318 adopted as amended.

Resolution 318 asks that our AMA amend Policy H-275.953, “The Grading Policy for Medical Licensure Examinations,” by addition and deletion to read as follows:

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.

3. Our AMA will ~~work with~~ convene the appropriate stakeholders to study ~~alternate means of~~ possible mechanisms for transitioning scoring of the USMLE exams to a Pass/Fail system in order to avoid the inappropriate use of USMLE scores for screening residency applicants while still affording program directors adequate information to meaningfully and efficiently assess medical student applications, and that the recommendations of this study be made available by the 2019 Interim Meeting of the AMA House of Delegates.

Your Reference Committee heard testimony both online and in person largely in favor of Resolution 318. Supporters felt that our AMA should be taking a more proactive role in shaping the medical licensing examination scoring process. A clarifying proposal was made to include the osteopathic licensing examination in addition to the allopathic examination. Testimony elicited the fact that the National Board of Medical Examiners already has launched an initiative that will consider these important issues, and has invited the AMA to be a co-convener. An amendment therefore was proposed that would recognize this planned involvement. After considered discussion, your Reference Committee recommends that Resolution 318 be adopted as amended.

(18) RESOLUTION 305 - STANDARDIZATION OF MEDICAL LICENSING TIME LIMITS ACROSS STATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 305 be referred.

HOD ACTION: Resolution 305 referred.

Resolution 305 asks 1) that our AMA amend Policy H-275.978, **"**Medical Licensure," by addition to read as follows**:**
The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information

collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. <u>(23) urges the state medical and osteopathic licensing boards which maintain a time limit on complete licensing examination sequences to adopt a time limit of no less than 10 years for completion of a licensing examination sequence for either USMLE or COMLEX.</u>

Your Reference Committee heard testimony in favor of referring this complex item for further study. Some states have no time limit for completion of the licensing examination sequence; some set a time limit of seven years; and some cap eligibility at 10 years (to accommodate the longer timeline for dual-degree individuals, i.e., those seeking to hold MD and PhD credentials). Testimony was heard concerning the perception that physicians who have academic troubles will take longer to complete the sequence, such

that the time limit becomes a mechanism through which to ensure patient safety by eliminating these individuals from the practice of medicine. This belief, however, does not take into account the legitimate health or life issues that may affect a given physician and extend the time needed for completion, or the challenges faced by dual-degree candidates. Testimony in favor of a time limit was that this would ensure that examinees are being assessed based on their current medical knowledge. A comprehensive, holistic review and study of all the relevant factors and consideration of potential unintended consequences is needed, to include all relevant stakeholders, such as the Federation of State Medical Boards and the 70 state medical and osteopathic regulatory boards it represents. Therefore, your Reference Committee recommends that Resolution 305 be referred.

(19) RESOLUTION 307 - HEALTHCARE FINANCE IN THE MEDICAL SCHOOL CURRICULUM

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 307 be referred.

HOD ACTION: Resolution 307 referred.

Resolution 307 asks 1) That our AMA study the extent to which medical schools and residency programs are teaching topics of healthcare finance and medical economics; and 2) That our AMA make a formal suggestion to the LCME encouraging the addition of a new Element, 7.10, under Standard 7, “Curricular Content,” that would specifically address the role of healthcare finance and medical economics in undergraduate medical education.

Your Reference Committee heard mixed testimony on this resolution. Testimony established that health care finance is already being taught in some medical schools, but an overall understanding of the breadth, depth, and frequency of these offerings is unknown. Simultaneously, there is concern that the second resolve implies a curricular mandate in an already distended medical education curriculum. Your Reference Committee is sensitive to the concerns of those responsible for curricular integrity, but feels that additional study of this topic is warranted. Therefore, your Reference Committee recommends that Resolution 307 be referred.

(20) RESOLUTION 314 - BOARD CERTIFICATION CHANGES IMPACT ACCESS TO ADDICTION MEDICINE SPECIALISTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 314 be referred.

HOD ACTION: Resolution 314 referred.

Resolution 314 asks that our AMA work with the American Board of Addiction Medicine (ABAM) and American Board of Medical Specialties (ABMS) to accept ABAM board certification as equivalent to any other ABMS-recognized Member Board specialty as a requirement to enroll in the transitional maintenance of certification program and to qualify for the ABMS Addiction Medicine board certification examination.

Your Reference Committee heard mixed testimony concerning the requirements for ABMS board certification in addiction medicine, centered around the equivalency of ABAM and ABMS board certification. Although a number of physicians have held ABAM certification, they do not meet the requirements for ABMS subspecialty certification in addiction medicine if they do not hold current ABMS certification in a primary specialty. Specific testimony during the hearing was to explore a pathway leading to lifetime certification. It was also noted that, although certification is not required to practice medicine, there was concern that this may be a requirement for hospital privileges. However, Policy H-275.924 (15), "Maintenance of Certification," states that "The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation." Although there is an urgent need to address this issue due to the current opioid crisis, your Reference Committee felt that this complex issue required further study, and therefore recommends referral of Resolution 314.

(21) RESOLUTION 316 - END "PART 4 IMPROVEMENT IN MEDICAL PRACTICE" REQUIREMENT FOR ABMS MOC®

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 316 be referred.

HOD ACTION: Resolution 316 referred.

Resolution 316 asks that our AMA call for an end to the mandatory American Board of Medical Specialties "Part 4 Improvement in Medical Practice" maintenance of certification requirement.

Your Reference Committee heard mixed testimony regarding the Part 4 requirement for American Board of Medical Specialties (ABMS) maintenance of certification (MOC). There was testimony concerning the relevance, burden, and cost of the MOC Part 4 process in addition to the other requirements physicians are required to fulfill for meaningful use, MACRA, etc. However, it was also noted that the broadening range of acceptable activities that meet the Improvement in Medical Practice (MOC Part 4) component has made this activity acceptable for other national value-based reporting requirements and continuing certification programs. It was also noted that the boards are implementing a number of activities related to registries, systems-based practice, and practice audits to show improvement in practice. The ABMS Multi-Specialty Portfolio Program offers health care organizations a way to support physician involvement in their institution's quality and performance improvement initiatives by offering credit for the Improvement in Medical Practice component of the ABMS Program for MOC. Due to the Council on Medical Education's ongoing work with the ABMS and the ABMS member

boards to improve this process, your Reference Committee felt that this issue should be referred for further study. Therefore, your Reference Committee recommends that Resolution 316 be referred.

(22) RESOLUTION 317 - EMERGING TECHNOLOGIES (ROBOTICS AND AI) IN MEDICAL SCHOOL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 317 be referred.

HOD ACTION: Resolution 317 referred.

Resolution 317 asks 1) That our AMA encourage medical schools to evaluate and update as appropriate their curriculum to increase students' exposure to emerging technologies, in particular those related to robotics and artificial intelligence; 2) That our AMA encourage medical schools to provide student access to computational resources like cloud computing services; 3) That our AMA reaffirm H-480.988 which 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 4) That our AMA reaffirm Section 1.2.11 of the AMA Code of Ethics and H-480.996 that states the guidelines for the ethical development of medical technology and innovation in healthcare.

Your Reference Committee heard mostly supportive testimony related to Resolution 317. This testimony noted that medical students will need access to these new types of technology to be better prepared for practice. The need for continued ethical guidance also was referenced. In opposition, it was argued that the appropriate place for instruction in these new technologies is at the graduate medical education rather than undergraduate level, as most of these types of technology are specialty specific. Your Reference Committee has been advised that the Council on Medical Education will be presenting a report to the HOD at A-19 on AI across the medical education continuum. Therefore, your Reference Committee recommends that Resolution 317 be referred and considered for inclusion in that report.

(23) RESOLUTION 309 - FOREIGN TRAINED IMGS COMPETENCY-BASED SPECIALTY EXAM WITHOUT U.S. RESIDENCY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 309 not be adopted.

HOD ACTION: Resolution 309 not adopted.

Resolution 309 asks that our AMA work with other stakeholders including the Accreditation Council of Graduate Medical Education, Association of American Medical Colleges and the American Board of Medical Specialties, to advocate that International Medical Graduates who have completed residency programs in their own countries should be eligible to take the specialties exam without being required to complete additional residency training in the U.S.

Your Reference Committee heard testimony largely in opposition to adoption of Resolution 309. That said, testimony also reflected support for the spirit of this proposal, from a workforce perspective, and as a mechanism to help speed the incorporation of international medical graduates, who provide many invaluable contributions to our society, into the U.S. health care system. It was noted that the current system of requiring an otherwise highly qualified physician from abroad to repeat a residency program in the United States may be archaic, even draconian, but that replacing this imperfect system with a single year of residency or a multiple-choice board certification examination is problematic at best. The systems of education, accreditation, and certification throughout the world are highly variable; allowing for an overly open system could put patients at risk. Another potential scenario presented through testimony was concerning as well: A U.S. medical school graduate who was unable to enter into a residency program here could go outside the U.S. for graduate medical education and then return through this proposed pathway. Additional testimony noted that accredited residency programs in the U.S. have aspects that are unique, including the six general competencies of the Accreditation Council for Graduate Medical Education (ACGME). Further, completing an ACGME-accredited residency program goes beyond clinical aspects, by helping acculturate IMGs to the practice and culture of medicine and health care in the U.S., which may be drastically different from that of their home countries. Finally, some member boards of the American Board of Medical Specialties already offer special accelerated pathways to practice for IMGs who meet specific metrics. For all these reasons, your Reference Committee therefore recommends that Resolution 309 not be adopted.

Madam Speaker, this concludes the report of Reference Committee C. I would like to thank Grayson Armstrong, MD, MPH; Cheryl Gibson Fountain, MD; Alan K. Klitzke, MD; David N. Lewin, MD; Kimberly Jo Templeton, MD; and Jessica Walsh O'Sullivan, and all those who testified before the committee, as well as our AMA staff, including Catherine Welcher, Carrie Radabaugh, Fred Lenhoff, Victoria Elliott, and Alejandro Aparicio, MD.

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