**DISCLAIMER**

**The following is a preliminary report of actions taken by the House of Delegates at its 2018 Interim 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 (I-18)

Report of Reference Committee C

Peter C. Amadio, MD, Chair

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1 Your Reference Committee recommends the following consent calendar for acceptance:
2
3 **RECOMMENDED FOR ADOPTION**
4
5 1. Council on Medical Education Report 5 – Reconciliation of AMA Policy on
6 Medical Student Debt
7 2. Council on Medical Education Report 6 – Reconciliation of AMA Policy on
8 Resident/Fellow Contracts and Duty Hours
9 3. Resolution 951 – Prevention of Physician and Medical Student Suicide
10 4. Resolution 953 – Support for the Income-Driven Repayment Plans
11 5. Resolution 954 – VHA GME Funding
12 6. Resolution 955 – Equality for COMLEX and USMLE
13
14 **RECOMMENDED FOR ADOPTION AS AMENDED**
15
16 7. Council on Medical Education Report 1 – Competency of Senior Physicians
17 8. Council on Medical Education Report 3 – Developing Physician-Led Public
18 Health/Population Health Capacity in Rural Communities
19 9. Council on Medical Education Report 4 – Reconciliation of AMA Policy on
20 Primary Care Workforce
21 10. Resolution 956 – Increasing Rural Rotations During Residency
22 11. Resolution 957 – Board Certifying Bodies
23 12. Resolution 961 – Protect Physician-Led Medical Education
24
25 **RECOMMENDED FOR REFERRAL**
26
27 13. Resolution 959 – Physician and Medical Student Mental Health and Suicide
28
29 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**
30
31 14. Resolution 960 – Inadequate Residency Slots
32
33 Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation
34 Consent Calendar:
35
36 Resolution 958 – National Health Service Corps Eligibility
37

1 Note: The following two items were withdrawn and not considered.
2
3 Resolution 952 – IMG Section Member Representation on Committees/Task
4 Forces/Councils
5
6 Resolution 962 – Improve Physician Health Programs

1 (1) COUNCIL ON MEDICAL EDUCATION REPORT 5 -
2 RECONCILIATION OF AMA POLICY ON MEDICAL
3 STUDENT DEBT
4
5 RECOMMENDATION:
6
7 Madam Speaker, your Reference Committee recommends
8 that the recommendations in Council on Medical Education
9 Report 5 be adopted and the remainder of the report be
10 filed.
11
12 **HOD ACTION: Council on Medical Education Report 5**
13 **adopted and the remainder of the report filed.**
14
15
16 Council on Medical Education Report 5 asks:
17 1. That our American Medical Association (AMA) adopt as policy "Principles of and Actions
18 to Address Medical Education Costs and Student Debt" the language shown in column 1
19 of Appendix A of this report; and
20 2. That our AMA rescind the following policies, as shown in Appendix C:
21 • D-305.956, "AMA Participation in Reducing Medical Student Debt"
22 • D-305.957, "Update on Financial Aid Programs"
23 • D-305.962, "Tax Deductibility of Student Loan Payments"
24 • D-305.966, "Reinstatement of Economic Hardship Loan Deferment"
25 • D-305.970, "Proposed Revisions to AMA Policy on Medical Student Debt"
26 • D-305.975, "Long-Term Solutions to Medical Student Debt"
27 • D-305.977, "Deductibility of Medical Student Loan Interest"
28 • D-305.978, "Mechanisms to Reduce Medical Student Debt"
29 • D-305.979, "State and Local Advocacy on Medical Student Debt"
30 • D-305.980, "Immediate Legislative Solutions to Medical Student Debt"
31 • D-305.981, "Financing Federal Consolidation Loans"
32 • D-305.993, "Medical School Financing, Tuition, and Student Debt"
33 • D-405.986, "Student Loans and Medicare / Medicaid Participation"
34 • H-305.926, "Supporting Legislation to Create Student Loan Savings Accounts"
35 • H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt"
36 • H-305.932, "State and Local Advocacy on Medical Student Debt"
37 • H-305.948, "Direct Loan Consolidation Program"
38 • H-305.954, "Repayment of Medical School Loans"
39 • H-305.965, "Student Loans"
40 • H-305.980, "Student Loan Repayment Grace Period"
41 • H-305.991, "Repayment of Educational Loans"
42
43 Your Reference Committee heard testimony uniformly in favor of the Council on Medical
44 Education's work on consolidating and reconciling multiple AMA policies on this important
45 topic. Limited testimony was received requesting addition of the word "service" to item 5
46 of the proposed new policy ("Encourage the National Health Service Corps to have service
47 repayment policies that are consistent with other federal loan forgiveness programs"), but
48 your Reference Committee believes this addition is not currently reflected in existing

policy, and therefore would be outside the permissible parameters of a reconciliation report. (See AMA Policy G-600.111, “Consolidation and Reconciliation of AMA Policy,” which states: “(4) The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning.”) Therefore, your Reference Committee recommends that Council on Medical Education Report 5 be adopted and the remainder of the report be filed.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 6 - RECONCILIATION OF AMA POLICY ON RESIDENT/ FELLOW CONTRACTS AND DUTY HOURS

RECOMMENDATION:

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

**HOD ACTION: Council on Medical Education Report 6 adopted and the remainder of the report filed.**

Council on Medical Education Report 6 asks:
1. That our American Medical Association (AMA) adopt the proposed revisions shown in Appendix A, column 1, for the following three policies:
- H-310.907, “AMA Duty Hours Policy” (with revised title: “Resident/Fellow Clinical and Educational Work Hours”)
- H-310.912, “Residents and Fellows’ Bill of Rights”
- H-310.929, “Principles for Graduate Medical Education”

2. That our AMA rescind the following seven policies, as shown in Appendix C, and incorporate relevant portions of four of these policies into existing AMA policy:
- D-310.987, “Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety”
- H-310.922, “Determining Residents’ Salaries”
- H-310.932, “Annual Contracts for Continuing Residents”
- H-310.947, “Revision of the ‘General Requirements’ of the Essentials of Accredited Residency Programs”
- H-310.979, “Resident Physician Working Hours and Supervision”
- H-310.988, “Adequate Resident Compensation”
- H-310.999, “Guidelines for Housestaff Contracts or Agreements”

Your Reference Committee heard testimony uniformly in favor of the Council on Medical Education’s work on consolidating and reconciling multiple AMA policies on this important topic. Limited testimony was provided that a revision to H-310.912, “Residents and Fellows’ Bill of Rights,” section E.(3), to replace “maternity and paternity leave” with “family and medical leave,” could be problematic for PGY-1 resident physicians, if interpreted as referring to the federal Family Medical Leave Act (FMLA). The Council on Medical Education clarified the intent of the policy to be broader than the FMLA; your Reference Committee therefore recommends adoption of Council on Medical Education Report 6.

(3) RESOLUTION 951 - PREVENTION OF PHYSICIAN AND MEDICAL STUDENT SUICIDE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 951 be adopted.

**HOD ACTION: Resolution 951 adopted.**

Resolution 951 asks: That our American Medical Association request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events.

Online testimony regarding this item was supportive of the resolution's intent, although some testimony noted that the Council on Medical Education is currently writing a report related to this topic, and suggested referral. Your Reference Committee heard impassioned in-person testimony regarding the devastating effects of burnout and depression, and all who spoke were in agreement regarding the urgency of this issue. Additional testimony agreed that collection of data by the bodies named in this resolution is an important step, but also highlighted that those named groups work only with medical students and residents, and that these data are also needed for physicians who have completed their training. Your Reference Committee agrees, and encourages the Council on Medical Education to consider this data gap when presenting their related report to the HOD at the 2019 Annual Meeting. Overall, however, this resolution commanded widespread support. Therefore, your Reference Committee recommends that Resolution 951 be adopted.

(4) RESOLUTION 953 - SUPPORT FOR THE INCOME-DRIVEN REPAYMENT PLANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 953 be adopted.

**HOD ACTION: Resolution 953 adopted.**

Resolution 953 asks: That our American Medical Association advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden.

Your Reference Committee heard uniformly positive testimony on this item. Our AMA policy supports maintaining and expanding both state and federal programs that minimize the impact of student loan debt on the pursuit of a career in medicine. As such, income-driven repayment plans are critical programs that enable a diverse range of students the ability to specialize in their desired discipline within the profession's workforce. These plans relieve the burden of medical student loan debt by setting loan payments as a percentage of the new physician's income. Payments become more manageable with the

repayment period extended from the standard 10 years to up to 25 years, and the remaining balance can be forgiven at the end of that period. Lifting the burden of medical student debt through the evaluation and development of feasible and effective loan forgiveness programs is a laudable goal for our AMA; your Reference Committee believes this resolution provides our AMA the means to this end. Therefore, your Reference Committee recommends that Resolution 953 be adopted.

(5) RESOLUTION 954 - VHA GME FUNDING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolves 1 and 2 of Resolution 954 be adopted.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolve 3 in Resolution 954 be referred.

**HOD ACTION: Resolves 1 and 2 of Resolution 954 adopted and Resolve 3 referred.**

Resolution 954 asks: That our American Medical Association continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; That our AMA collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration (VHA) funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process; and That our AMA oppose service obligations linked to VHA GME residency or fellowship positions, particularly for resident physicians rotating through the VA for only a portion of their GME training.

Your Reference Committee heard mixed testimony on this resolution. Our AMA has long been an advocate for preservation and expansion of GME funding to mitigate projected physician shortages and ensure that positions are available for medical school graduates applying to residency programs. Currently, there are no service obligations for VA residency programs, and our AMA does not have existing policy opposing a GME expansion plan linked to a service obligation. However, it was noted that all funding for residency/fellowship positions, whether from private, Veterans Administration (VA), and/or Centers for Medicare & Medicaid Services (CMS) sources, carries with it the expectation that residents/fellows perform service for patients during their years in the training program. Due to the complicated rules at institutions that sponsor residency programs related to full funding for a resident full-time employee, it was recommended that Resolve 3 be referred for further study. Therefore, your Reference Committee recommends that Resolves 1 and 2 of Resolution 954 be adopted and Resolve 3 be referred.

(6) RESOLUTION 955 - EQUALITY FOR COMLEX AND USMLE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 955 be adopted.

**HOD ACTION: Resolution 955 adopted.**

Resolution 955 asks: That our American Medical Association promote equal acceptance of the USMLE and COMLEX at all United States residency programs; That our AMA work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and That our AMA work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.

Your Reference Committee heard strong testimony in support of this resolution. Testimony acknowledged that the United States Medical Licensing Examination (USMLE) and Comprehensive Osteopathic Medical Licensing Examination (COMLEX) are credentialing examinations that have been increasingly used in recent years as selection criteria for acceptance into a residency program, which is not their intended purpose. Testimony also noted the high costs of these examinations and the large disparity between program directors' usage of the examinations for residency selection criteria, with greater preference for the USMLE over the COMLEX, despite testimony indicating a strong correlation of scores among people who take both exams. This resolution is calling for equal acceptance of the USMLE and COMLEX at all U.S. residency programs. This is consistent with HOD Policy H-275.953, "The Grading Policy for Medical Licensure Examinations," which promotes the principle that selection of residents should be based on a broad variety of evaluative criteria, and proposes that ACGME program requirements state clearly that residency program directors not use NBME or USMLE ranked passing scores as a screening criterion for residency selection. This issue is timely as the single accreditation pathway and National Resident Matching Program will be the primary avenue that all osteopathic medical students will participate in for residency application. In addition, the COMLEX examination is a graduation requirement for all osteopathic medical students, and the examination taken by one in five future physicians is a measurement tool that all program directors should be familiar with and accept. Therefore, your Reference Committee recommends that Resolution 955 be adopted.

(7) COUNCIL ON MEDICAL EDUCATION REPORT 1 - COMPETENCY OF SENIOR PHYSICIANS

RECOMMENDATION A:

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

1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles:

   a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. ~~Current research suggests that physician competency and practice performance decline with increasing years in practice~~ Some physicians may suffer from declines in practice performance with advancing age. ~~However, r~~Research ~~also~~ suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging.

   e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. ~~When public health or patient safety is directly threatened, removal from practice is one potential outcome.~~

RECOMMENDATION B:

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

**HOD ACTION: Council on Medical Education Report 1 referred.**

Council on Medical Education Report 1 asks: 1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles: a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging. b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency. c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians' ability to perform the tasks specifically required in their practice environment. d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results. e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome. f) Transparent: Guidelines, procedures or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment. g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive. h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems; 2. That our AMA encourage the Federation of State Medical Boards, Council of Medical Specialty Societies, and other interested organizations to develop educational materials on the effects of age on physician practice for senior/late career physicians; and 3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report.

Your Reference Committee heard strong support for Council on Medical Education Report 1. This report outlines a set of Guiding Principles developed by the Council on Medical Education, with extensive feedback and assistance from our AMA's Work Group on Assessment of Senior/Late Career Physicians, which included key stakeholders representing physicians, medical specialty societies, accrediting and certifying organizations, hospitals and other health care institutions, and patients' advocates, as well as other content experts who research physician competence and administer assessment programs. The Guiding Principles provide direction and serve as a reference for the

development of guidelines for screening and assessing senior/late career physicians. Other testimony alluded to the application of the Guiding Principles, and queried whether our AMA was advocating for a screening process for senior/late career physicians. Further testimony from the Council on Medical Education clarified that this is not the case, and that the Principles are intended to ensure that physicians can self-advocate when discussions regarding their competency are raised by their institutions or practices. In addition, the first recommendation (Guiding Principle 1.a) was amended to reflect testimony that not all physicians suffer from declines in practice performance with advancing age. Your Reference Committee also deleted text in Guiding Principle 1.e that appeared to be redundant. Your Reference Committee therefore recommends that Council on Medical Education Report 1 be adopted as amended.

(8) COUNCIL ON MEDICAL EDUCATION REPORT 3 - DEVELOPING PHYSICIAN-LED PUBLIC HEALTH/ POPULATION HEALTH CAPACITY IN RURAL COMMUNITIES

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:

That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially encourage dissemination to women physician groups and other groups typically ~~and those who are~~ underrepresented in medicine. (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: 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-295.311, "Developing Physician Led Public Health / Population Health Capacity in Rural Communities," be rescinded, as having been fulfilled by this report;
2. That our American Medical Association (AMA) reaffirm the following policies:

- D-295.327, "Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum"

- D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion"
- D-305.974, "Funding for Preventive Medicine Residencies"
- H-425.982, "Training in the Principles of Population-Based Medicine"
- D-440.951, "One-Year Public Health Training Options for all Specialties"
- H-440.954, "Revitalization of Local Public Health Units for the Nation"
- H-440.888, "Public Health Leadership"
- H-440.969, "Meeting Public Health Care Needs Through Health Professions Education"

3. That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially to women and those who are underrepresented in medicine; and 4. That our AMA encourage public health leadership programs to evaluate the effectiveness of various leadership interventions.

Online testimony regarding this report was unanimously supportive. Testimony specifically applauded the report's thorough listing of currently available training opportunities across the continuum, as well as the call for relevant organizations to highlight learning opportunities in rural and public health. Your Reference Committee also heard overwhelmingly positive in-person testimony, which noted that the report effectively addresses the HOD mandate to study innovative approaches that support interested physicians as they seek qualifications and credentials in preventive medicine/public health to strengthen public health leadership. Testimony also, however, identified important related policy gaps, and your Reference Committee agrees that our AMA should consider future policy that addresses these gaps, such as emphasizing concrete steps physicians currently practicing in rural areas can take to enhance their own public/population health skills. A minor editorial change was proposed to one of the report's recommendations, which your Reference Committee agrees will strengthen the report's policy impact. Therefore, your Reference Committee recommends that Council on Medical Education Report 3 be adopted as amended.

(9) COUNCIL ON MEDICAL EDUCATION REPORT 4 - RECONCILIATION OF AMA POLICY ON PRIMARY CARE WORKFORCE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Recommendation 1 in Council on Medical Education 4 be amended by addition and deletion, to read as follows:

That our American Medical Association (AMA) adopt as policy "Principles of and Actions to Address Primary Care Workforce" the language shown in column 1 in Appendix A to this report, with the following deletion to item 8. (New HOD Policy)

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued~~, including such innovations as a three-year medical school curriculum that leads directly to primary care residency programs~~. The establishment of appropriate administrative units for all primary care specialties ~~family medicine~~ should be encouraged.

RECOMMENDATION B:

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

**HOD ACTION: Council on Medical Education Report 4 adopted as amended and the remainder of the report filed.**

Council on Medical Education Report 4 asks:
1. That our American Medical Association (AMA) adopt as policy “Principles of and Actions to Address Primary Care Workforce” the language shown in column 1 in Appendix A to this report;
2. That our AMA rescind the following policies, as shown in Appendix C:

- D-200.979, “Barriers to Primary Care as a Medical School Choice”
- D-200.994, “Appropriations for Increasing Number of Primary Care Physicians”
- H-200.956, “Appropriations for Increasing Number of Primary Care Physicians”
- H-200.966, “Federal Financial Incentives and Medical Student Career Choice”
- H-200.973, “Increasing the Availability of Primary Care Physicians”
- H-200.975, “Availability, Distribution and Need for Family Physicians”
- H-200.977, “Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians”
- H-200.978, “Loan Repayment Programs for Primary Care Careers”
- H-200.982, “Significant Problem of Access to Health Care in Rural and Urban Underserved Areas”
- H-200.997, “Primary Care”
- H-295.956, “Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers”
- H-300.957, “Promoting Primary Care Services Through Continuing Medical Education”
- H-310.973, “Primary Care Residencies in Community Hospitals”

3. That H-200.972, “Primary Care Physicians in the Inner City,” be amended by addition and deletion, and a title change, to read as follows:
“Primary Care Physicians in Underserved Areas”
Our AMA should pursue the following plan to improve the recruitment and retention of physicians in ~~the inner city~~ underserved areas: (1) Encourage the creation and pilot-testing of school-based, ~~church~~ faith-based, and community-based urban/rural “family ~~H~~health clinics, with an emphasis on health education, prevention, primary care, and prenatal care. (2) Encourage the affiliation of these family health clinics with ~~urban~~ local medical schools

and teaching hospitals. ~~(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts. (4) Encourage medical schools and teaching hospitals to integrate third- and fourth-year undergraduate medical education and residency training into these teams.~~ (~~5~~3) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies. ~~(6) Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies. (7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently.~~ (~~8~~4) Encourage the AMA Senior Physicians ~~Services Group~~ Section to consider the ~~use~~ involvement of retired physicians in underserved ~~urban~~ settings ~~of retired physicians~~, with appropriate mechanisms to ensure their competence. (~~9~~5) Urge ~~urban~~ hospitals and medical societies to develop opportunities for physicians to work part-time to staff ~~urban~~ health clinics that help meet the needs of underserved patient populations. (~~10~~6) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who ~~serve the inner-city poor~~ help meet the needs of underserved patient populations. ~~(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination. (12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school. (13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care.(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states.~~(~~15~~7) Urge ~~urban~~ hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to ~~fill gaps in urban care~~ help meet the needs of underserved patient populations. ~~(16) Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings. (17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.(18) Continue to urge measures to enhance payment for primary care in the inner city.~~

Your Reference Committee heard testimony overwhelmingly in support of the work of the Council on Medical Education on reconciling multiple AMA policies on this important topic. One friendly amendment was proffered to the Council on Medical Education prior to the Reference Committee hearing by the Young Physicians Section, which noted that a phrase in item 8 of the proposed new policy was not currently reflected in existing policy, and therefore would be outside the permissible parameters of a reconciliation report. (See AMA Policy G-600.111, "Consolidation and Reconciliation of AMA Policy," which states: "[4.] The consolidation process permits editorial amendments for the sake of clarity, so long as the proposed changes are transparent to the House and do not change the meaning.") This deletion was supported by other delegations that testified. Therefore, your Reference Committee recommends that Council on Medical Education Report 4 be adopted as amended.

(10) RESOLUTION 956 - INCREASING RURAL ROTATIONS DURING RESIDENCY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolve 1 of Resolution 956 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors~~,~~ and volunteer faculty~~, etc.~~ for rural rotations in residency (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolve 2 of Resolution 956 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA work with the ACGME, the American Board of Medical Specialties, the Federation of State Medical Boards, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas (Directive to Take Action); and be it further~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolve 3 of Resolution 956 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates and that our AMA work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas. (Directive to Take Action)~~; and be it further~~

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolve 4 of Resolution 956 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA work with state and specialty societies and other interested stakeholders to identify appropriately qualified rural physicians who would be willing to serve as preceptors for rural rotations in residency (Directive to Take Action); and be it further~~

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolve 5 of Resolution 956 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA work with the ACGME and other interested stakeholders to lessen the documentation requirements for off-site rural rotations during residency so that affiliated rural supervising faculty can focus on educating rotating residents (Directive to Take Action); and be it further~~

RECOMMENDATION F:

Madam Speaker, your Reference Committee recommends that Resolve 6 of Resolution 956 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA work with interested stakeholders to study other ways to increase training in rural areas (Directive to Take Action); and be it further~~

RECOMMENDATION G:

Madam Speaker, your Reference Committee recommends that Resolve 7 of Resolution 956 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA formulate an actionable plan of advocacy based on the results of the above study with the goal of increasing residency training in rural areas. (Directive to Take Action)~~

RECOMMENDATION H:

Madam Speaker, your Reference Committee recommends that Resolution 956 be adopted as amended.

**HOD ACTION: Resolution 956 adopted as amended.**

Resolution 956 asks: That our American Medical Association work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to encourage and incentivize qualified rural physicians to serve as preceptors, volunteer faculty, etc. for rural rotations in residency; That our AMA work with the ACGME, the American Board of Medical Specialties, the Federation of State Medical Boards, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas; That our AMA work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; That our AMA work with state and specialty societies and other interested stakeholders to identify appropriately qualified rural physicians who would be willing to serve as preceptors for rural rotations in residency; That our AMA work with the ACGME and other interested stakeholders to lessen the documentation requirements for off-site rural rotations during residency so that affiliated rural supervising faculty can focus on educating rotating residents; That our AMA work with interested stakeholders to study other ways to increase training in rural areas; and That our AMA formulate an actionable plan of advocacy based on the results of the above study with the goal of increasing residency training in rural areas.

Online testimony was mostly supportive of the resolution's intent, although Resolves 2 and 5 were recommended against adoption by the Council on Medical Education because our AMA lacks authority to define residency regulations or requirements. In-person testimony also strongly supported this resolution, with multiple delegates highlighting the problems associated with physician maldistribution, the importance of exposure to rural practice for all trainees, and the barriers programs face when attempting to provide this exposure. Significant amendments were offered during the hearing, which help to clarify and focus the impact of this item. Your Reference Committee therefore recommends that Resolution 956 be adopted as amended.

(11) RESOLUTION 957 - BOARD CERTIFYING BODIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolve 1 of Resolution 957 be amended by addition and deletion, to read as follows:

RESOLVED, That our American Medical Association ~~conduct a~~continue studying ~~of~~ the certifying bodies that compete with the American Board of Medical Specialties and ~~issue~~provide an update in the Council on Medical Education's annual report on maintenance of certification at A-19 ~~opining on the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved;~~.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolve 2 of Resolution 957 be amended by deletion, to read as follows:

~~RESOLVED, That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification.~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 957 be adopted as amended.

**HOD ACTION: Resolution 957 adopted as amended.**

Resolution 957 asks: That our American Medical Association conduct a study of the certifying bodies that compete with the American Board of Medical Specialties and issue a report opining on the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved; and That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification.

Your Reference Committee heard mixed online and in-person testimony on this item. Testimony noted that the Council on Medical Education studied the available certification processes for physicians and reported to the HOD in Council on Medical Education Reports 2-A-16 and 2-A-17, both of which were adopted. It was also noted that the

resolution's reference to the list of certifying entities may be potentially inaccurate since only those state medical boards that regulate physician use of the term "board certified" maintain a list of "approved certifying entities." Our AMA maintains robust policy on maintenance of certification (MOC), including policy related to state legislative efforts. Our AMA has also developed two model bills, including the Right to Treat Act, which prohibits licensing boards, hospitals, and insurers from requiring a physician to maintain certification for licensure, licensure renewal, hospital staff or admitting privileges, or reimbursement. In addition, our AMA's Truth in Advertising Act contains a drafting note that allows for physicians certified by the American Board of Medical Specialties (ABMS) and American Osteopathic Association (AOA) and certain alternative specialty certification boards to advertise themselves as being board certified. This model legislation specifically allows a pathway by which non-ABMS/AOA specialty boards may demonstrate their validity. The ABMS and AOA are both private entities whose standards are not subject to regulation by the AMA, and thus, model legislation to that effect would not be effective. Furthermore, action by our AMA to develop model legislation that separates continuing board certification/MOC from board certification could eventually invite government intervention and oversight, resulting in more tedious physician bureaucracy and regulation. That said, there was still concern expressed via testimony about lowering the costs for physicians to be certified and improving the quality of certification services. The Council continues to be actively engaged in following the work of the Vision for the Future Commission, which is scheduled to release recommendations to the ABMS regarding the future of continuing certification in February 2019. The Council will address the Vision Commission's recommendations fully in its A-19 report on this topic. Accordingly, for all of the above reasons, your Reference Committee recommends that Resolution 957 be adopted as amended.

(12) RESOLUTION 961 - PROTECT PHYSICIAN-LED MEDICAL EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Policy H-310.912 and H-295.955 be reaffirmed in lieu of Resolve 1 of Resolution 961.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolve 2 of Resolution 961 be amended by addition and deletion, to read as follows:

RESOLVED, That our AMA ~~provide~~ publicize to medical students, residents, and fellows ~~a clear online resource outlining~~ their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 961 be adopted as amended.

**HOD ACTION: Resolution 961 adopted as amended, with an amended Resolve 1, to read as follows:**

**RESOLVED, That our American Medical Association~~, in their role as a member organization of the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education,~~ strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education ~~be trained, supervised, and evaluated by licensed physicians~~. (Directive to Take Action).**

Resolution 961 asks: That our American Medical Association, in their role as a member organization of the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education, strongly advocate for the rights of medical students, residents, and fellows to be trained, supervised, and evaluated by licensed physicians; and That our AMA provide medical students, residents, and fellows a clear online resource outlining their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation.

Your Reference Committee heard mixed testimony on this item, with support for adoption, referral, and reaffirmation of current policy, highlighting both the complexity and importance of this issue. Many of those who testified on all sides of the issue prefaced their statements with accolades for the role of non-physician educators in their own education and training—analogous to our AMA's model of a physician-led team-based care paradigm that encourages non-physician involvement in a patient's care, under the overall guidance of a physician. That said, it is difficult to question the effectiveness of the physician educator/mentor in this role; physicians should provide education to the next generation of experts. In addition, students and trainees should be able to express concerns about the quality of their education, and their instructors, without fear of retribution from their respective institutions. Your Reference Committee believes that Resolve 1 is already reflected in two existing AMA policies, and recommends their reaffirmation in lieu of Resolve 1. These existing policies support the primacy of physician educators in the clinical setting, yet clearly value the contribution of non-physician educators. Your Reference Committee suggests additions and deletions to Resolve 2 to clarify the intended action and adoption of the Resolve as amended.

Policy recommended for reaffirmation:

H-310.912, "Residents and Fellows' Bill of Rights"

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.

6. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENTS AND FELLOWs' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory

responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences.

(3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act.

F. Duty hours that protect patient safety and facilitate resident well-being and education.

With regard to duty hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty-hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty-hour requirements are effectively circumvented.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

H-295.955, “Teacher-Learner Relationship In Medical Education”

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c)

protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher.

In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

(13) RESOLUTION 959 - PHYSICIAN AND MEDICAL STUDENT MENTAL HEALTH AND SUICIDE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 959 be referred.

**HOD ACTION: Resolution 959 referred.**

Resolution 959 asks: That our American Medical Association create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and mental health disease in physicians and medical students. This committee will be charged with: 1) Developing novel policies to decrease physician and medical trainee stress and improve professional satisfaction. 2) Vociferous, repeated and widespread messaging to physicians and medical students encouraging those with mood disorders to seek help. 3) Working with state medical licensing boards and hospitals to help remove any stigma of mental health disease and to alleviate physician and medical student fears about the consequences of mental illness and their medical license and hospital privileges. 4) Establishing a 24-hour mental health hotline staffed by mental health professionals whereby a troubled physician or medical student can seek anonymous advice. Communication via the 24-hour help line should remain anonymous. This service can be directly provided by the AMA or could be arranged through a third party, although volunteer physician counselors may be an option for this 24-hour phone service.

Online testimony regarding this item was supportive of the resolution's intent, but testimony also noted that the Council on Medical Education is currently writing a report related to this topic, and therefore recommended referral of this topic for inclusion in that report when it is presented to the HOD at the 2019 Annual Meeting. Your Reference Committee heard in-person testimony in support of much of the resolution, but testimony was mixed regarding calls for the establishment and staffing of a 24-hour mental health hotline. Many called for referral, noting that the Council on Medical Education could consider appropriate deliverables to further establish our AMA's leadership role in this space, and to make a recommendation regarding the establishment of and role for an AMA committee or task force related to this topic. The Council on Medical Education

testified that it will incorporate this content into its planned report to the HOD for the 2019 Annual Meeting. Therefore, your Reference Committee recommends that Resolution 959 be referred.

(14) RESOLUTION 960 - INADEQUATE RESIDENCY SLOTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy D-305.967(32) be reaffirmed in lieu of Resolution 960.

**HOD ACTION: Policy D-305.967(32) reaffirmed in lieu of Resolution 960.**

Resolution 960 asks: That our American Medical Association adopt policy to establish parity between the number of medical school graduates and the number of match positions and withhold support for any further increase in medical school enrollment, unless there is a corresponding increase in residency positions; and That our AMA lobby the federal government for increased funding for residency spots, to investigate other sustainable models for residency position funding and to advocate for loan repayment waivers for individuals who fail to match.

Your Reference Committee heard mixed testimony on this item, with the majority, however, in favor of reaffirmation of current policy. In June 2018, the House of Delegates approved the recommendations of Council on Medical Education Report 3-A-18, which was in turn incorporated into Policy D-305.967(32), further clarifying our AMA's policy on funding of residency slots. Some testimony noted a shortage of residency program slots for medical students seeking entry into graduate medical education, but this is not numerically factual unless international medical graduates are included in the total count of available residency slots. It was expressed that any sort of cap on medical student enrollment could send the wrong message, given current and projected shortages in many specialties and geographic areas, and could lead to potential unintended consequences and exacerbation of physician maldistribution in medically underserved areas, and possible restraint of trade concerns. The bulk of testimony was also opposed to any sort of loan repayment waiver for those who fail to match, which could lead to perverse incentives. Reports by our AMA Council on Medical Education are a better and more finely tuned mechanism for the continued evolution of AMA policy on this critical topic for physicians and our patients. In summary, your Reference Committee believes that existing policy covers the intent of this item, and recommends reaffirmation of this policy in lieu of Resolution 960.

Policy recommended for reaffirmation:

Policy D-305.967(32), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education"

Our AMA will: (a) 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; (b) 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)

1 programs that can accommodate the equivalent number of additional medical school
2 graduates consistent with the workforce needs of our nation; and (c) encourage the
3 Liaison Committee on Medical Education (LCME), the Commission on Osteopathic
4 College Accreditation (COCA), and other accrediting bodies, as part of accreditation
5 of allopathic and osteopathic medical schools, to prospectively and retrospectively
6 monitor medical school rates of placement into GME as well as GME completion.

1 Madam Speaker, this concludes the report of Reference Committee C. I would like to
2 thank Jerry P. Abraham, MD, MPH; John C. Moorhead, MD; Lucy Nam; Brigitta J.
3 Robinson, MD, FACS; Martin D. Trichtinger, MD, FACP; and Roxanne Tyroch, MD, FACP;
4 and all those who testified before the committee, as well as our AMA staff, including
5 Catherine Welcher; Carrie Radabaugh; Fred Lenhoff; and Susan Skochelak, MD, MPH.

Jerry P. Abraham, MD, MPH
American Academy of Family Physicians

John C. Moorhead, MD
American College of Emergency Physicians

Lucy Nam
Medical Student Section
(Alternate) Maryland

Brigitta J. Robinson, MD, FACS
(Alternate) Colorado

Martin D. Trichtinger, MD, FACP
Pennsylvania

Roxanne Tyroch, MD, FACP
(Alternate) Texas

Peter C. Amadio, MD
American Association for Hand Surgery
Chair