American Medical Association - Resident and Fellow Section

2017 Reports and Resolutions

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Memo to: AMA-RFS Assembly

From: Hans Arora, MD, PhD
AMA-RFS Chair

Date: June 2017

Subject: Items of Business before the RFS Reference Committee

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Late Resolution: 1  
(A-17)

Introduced by: Brooke Lamparello MD, Carolyn Heins MD, Abigail Lubin MD

Subject: Protection of Access and Insurance Coverage of Women’s Preventative and Maternity Care

Referred to: Reference Committee

Whereas, Access to birth control provides a myriad of health and socioeconomic benefits to women and children, improves women’s ability to control whether and when they have a child; and

Whereas, 98% of women have used birth control at some point in time; and

Whereas, The 2010 Affordable Care Act (ACA) requires insurance plans to cover at least one form of the 18 Food and Drug Administration (FDA)-approved methods of birth control for women without out-of-pocket costs; and

Whereas, 55 million women now have coverage of birth control without out-of-pocket costs; and

Whereas, In 2013 women saved an estimated $1.4 billion dollars on the oral contraceptive pill alone and, after the ACA passed, use of oral contraceptives doubled in women aged 18-24; and

Whereas, Only California, Illinois, and Vermont have existing legislation preventing cost sharing of contraceptive coverage; though recently, Washington D.C., Nevada and New York have introduced legislation ensuring continued coverage of contraception and preventative services; and

Whereas, Proposed replacement of the ACA, the American Health Care Act (AHCA), suggested drastic changes in insurance coverage and access to preventative care and maternity services for women that may greatly decrease coverage and limit access to affordable care; and

Whereas, On March 30, 2017 the Senate passed H.J. Res 43, which eliminates a regulation that prohibits states from receiving federal funds for reasons unrelated to their ability to provide healthcare services; and

Whereas, Removal of such regulations could remove federal funding from organizations that provide crucial women’s health services—particularly in low-resource settings; and

Whereas, The Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) estimated that by 2018, 14 million people would be uninsured under the proposed legislation than under current law; and

Whereas, Repeal of funding for the Prevention and Public Health Fund, established under the ACA, could result in states losing more than $3 billion dollars over five years; and
Whereas, on January 25, 2017 leaders from the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Congress of Obstetricians and Gynecologists, and American Osteopathic Association released a joint letter vocalizing support for women’s access to affordable healthcare, opposition of political interference in the provider-patient relationship, and protection of current insurance coverage and benefits for women; therefore be it

RESOLVED, That our AMA support the continued efforts and legislation that ensures women have comprehensive coverage and access to preventative care, contraceptives, and maternity care.

Fiscal Note:

References:


**Relevant RFS Policy and AMA Policy:**

**Coverage of Prescription Contraceptives by Insurance H-180.958**

Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives. (Res. 221, A-98; Reaffirmation A-04; Reaffirmed: CMS Rep. 1, A-14)

**Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement H-75.984**

1. Our AMA: (a) recognizes the practice of immediate postpartum and post pregnancy long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies; and (b) supports the coverage by Medicaid, Medicare, and private insurers for immediate postpartum long-acting reversible contraception devices and placement, and that these be billed separately from the obstetrical global fee.

2. Our AMA encourages relevant specialty organizations to provide training for physicians regarding (a) patients who are eligible for immediate postpartum long-acting reversible contraception, and (b) immediate postpartum long-acting reversible contraception placement protocols and procedures. (Res. 101, A-16)

**Preconception Care H-425.976**

1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:

   (1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;

   (2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;

   (3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;

   (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);

   (5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);

   (6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;

   (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and preconception and inter-conception care;

   (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;

   (9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and

   (10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health. (Res. 414, A-06; Reaffirmation I-07)
Whereas, Significant changes are occurring in the practice of medicine; and
Whereas, Physician leadership and engagement are necessary to assure that interests of patients and the medical profession are well served now and in the future; and
Whereas, Medical schools and teaching hospitals play a critical role in the education of young physicians; and
Whereas, Academic physicians and teaching physicians play a critical role in professional development of young physicians, serving as role models for patient advocacy and legislative engagement; and
Whereas, There are opportunities for advocacy and legislative action in our AMA and the state and county medical societies (organized medicine); and
Whereas, A significant number of new (and established) medical schools use community-based faculty and community hospitals for medical student education; therefore be it
RESOLVED, That our RFS support conducting studies on the participation of academic and teaching physicians, residents, fellows, and medical students, and community-based faculty members of medical schools and graduate medical education programs in organized medicine on medical school campuses and in teaching hospitals; and be it further
RESOLVED, That our RFS support identifying successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine at the training sites.

Fiscal Note: $5,000
Relevant RFS Policy and AMA Policy:

294.005R ACGME Allotted Time off for Health Care Advocacy and Policy Activities: That our AMA urge the ACGME to acknowledge that “activities in organized medicine” facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; That our AMA encourage all residency and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; That our AMA encourage the ACGME to adopt policy that every resident and fellow be allotted additional of time per year, beyond of scheduled vacation time, to be used for activities of organized medicine, including but not limited to, health care advocacy and health policy; That our AMA study the other barriers and possible options to overcome these barriers to resident and fellow involvement in of organized medicine, including but not limited to, health care advocacy and health policy. (Resolution 6, A-10)

Greater Involvement of Medical Students in Federation Organizations G-620.050
Our AMA encourages medical societies to provide mechanisms for more direct involvement of students at the state and local levels, and to implement membership options for their state's medical students who are enrolled in medical school for longer than four years. Our AMA will work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years. (CCB/CLRPD Rep. 3, A-12)

Curriculum Orientation of Medical Staff Membership in Teaching Programs H-310.994

Employed Physicians and the AMA G-615.105
1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.

2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.

3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. (Res. 601, I-11)

Federation Organizations and Organized Medical Staff G-620.080

Enhancing the Value of Membership in Organized Medicine G-620.060
The perspective of our AMA House on enhancing the value of membership in organized medicine includes the following: (1) The House adopts the goal of improving Federation performance as a whole;

(2) The House supports efforts to improve the Federation's business processes to include a new member early recognition and retention system and consolidated billing and application process;

(3) The House supports the redesign of Federation products and pricing to increase overall appeal and thus recruit additional members and improve retention;
(4) The House believes that the Federation should work together to leverage each organization's core competencies;

(5) The House encourages the testing of different strategic and operational collaborative arrangements at many sites and the use of these to improve Federation membership, pricing, and member service;

(6) The House encourages state medical associations and national medical specialty societies to review the composition of their AMA delegations;

(7) The House believes it is important to promote resident physician membership in national medical specialty societies;

(8) The House urges all county and state societies to implement a simple transfer of membership procedure to permit uninterrupted membership in organized medicine for physicians who relocate at any time during their careers, with such procedure containing the flexibility to permit resident AMA members to become regular state and county members through the transfer process; and

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1  
(A-17)

Introduced by: Jordan M. Warchol MD, Luke Selby MD, MS  
Subject: Improving FDA Expedited Approval Pathways  
Referred to: Reference Committee

Whereas, In the wake of the AIDS epidemic in the 1980s, FDA created pathways by which specialty drugs could be approved based on less rigorous data, including a “fast track” pathway for drugs that treat life-threatening or severely debilitating conditions, which allows approval on the basis of uncontrolled Phase II trials, and an “accelerated approval” pathway which lowers evidentiary requirements for drugs for serious or life-threatening conditions if the drug provides a meaningful therapeutic benefit not provided by existing treatment, both of which have reduced the time to approval for designated specialty drugs; and

Whereas, In the period of 2000-2013, 82 drugs were approved under the fast-track designation, representing 22% of all drugs including biologics approved by the FDA during that time period, yet only 49 of the 82 were specialty drugs; and

Whereas, In the same period of 2000-2013, 37 new drugs were granted accelerated approval (10% of all drugs including biologics), of which 26 were specialty drugs; and

Whereas, In 2012 the United States Congress created another expedited pathway for so-called “breakthrough therapies” which could be designated by FDA based on early clinical signs of promise, expected to be used only a few times a year but which received over 100 applications for designation in 2013; and

Whereas, These expedited pathways usually allow for drug approval some time during Phase III which lasts approximately from 1-4 years, and the standard drug approval process has a median approval time of 10.1 months from receipt of application, thereby resulting in expedited pathway approval approximately 5 years before said drug would be approved via the standard pathway, and

Whereas, These expedited approval pathways pose challenges to the evidence-based prescribing of approved drugs, since designations provide strong signals to the public about the clinical importance of the drugs entering these pathways and drugs that are approved after a shortened premarket period or drugs approved based on unvalidated surrogate endpoints may later be found to have greater risks, or less certain benefits, than was initially believed to be the case; and

Whereas, Approval of an expensive new specialty drug based only on preliminary data suggesting that it might improve patient outcomes and resultant use by clinicians may divert resources away from other health care interventions that have been confirmed to be effective or that present greater value; and

Whereas, These expedited pathways require post-approval testing to confirm the drugs’ predicted benefit-risk profiles, yet one 2011 review of forty-seven oncology drugs approved
through the “accelerated approval” pathway in the period 1992–2010 found that trials for
eighteen had not been completed at the time of the review; and

Whereas, FDA has limited power to ensure that mandatory post-approval trials for drugs
approved via these pathways be conducted in a timely and rigorous manner, being able to
impose civil fines of up to $10 million, which is but a fraction of the enormous profit specialty
drugs can generate; and

Whereas, Removing a drug from the market often draws criticism from physicians and patient-
advocacy groups, even for drugs which lack data supporting their effectiveness or safety; and

Whereas, A system by which approval for drugs brought forward under these expedited
pathways would be designated as temporary and have a set expiration date, with more
permanent FDA approval given under the condition of further evidence supporting safety and
efficacy, would shift the burden to the manufacturer to show that its drug should remain on the
market; and

Whereas, Legislative action would be required to further modify the FDA expedited pathway
processes; and

Whereas, Robert M. Califf, M.D., former FDA Commissioner noted that with the passage of the
21st Century Cures Act “great progress has been made towards our shared goal of advancing
regulatory science so that we can continue to speed the discovery, development, and delivery of
medical products to prevent and cure disease and improve health while sustaining the evidence
framework that enables assurance to the public of the safety and effectiveness of medical
products;” therefore be it

RESOLVED, That our AMA work with FDA and other interested stakeholders to design and
implement via legislative action (including ensuring appropriate FDA staffing) a process by
which drugs which obtain FDA approval via the Fast Track, Accelerated Approval, or
Breakthrough Therapy pathways be granted FDA approval on a temporary basis not to exceed
5 years, pending further evidence of safety and efficacy that is at the level set for the standard
drug approval process, and be it further

RESOLVED, That our AMA work with the FDA and other interested stakeholders in improving
the process by which drugs are selected for the expedited pathway to improve the prevalence of
these drugs that are classified as “specialty drugs.”

Fiscal Note:

References:
1. FY 2016 PERFORMANCE REPORT TO CONGRESS for the Prescription Drug User Fee Act
found at https://www.fda.gov/downloads/AboutFDA/ReportsManualsForms/Reports/UserFeeReports/Perfo-
2011;103(8):636–44.
https://blogs.fda.gov/fdavoice/index.php/2016/12/21st-century-cures-act-making-progress-on-
also obtained from: Kesselheim AS, Tan YT, Darrow JJ, Avorn J. Existing FDA Pathways Have

Relevant RFS Policy and AMA Policy:

FDA H-100.992
(1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug’s approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
(2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA’s decision-making process in the course of FDA devising either general or product specific drug regulation.
(3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. (Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation, A-06; Appended: Sub. Res. 509, A-06; Reaffirmation, I-07; Reaffirmation, I-09; Reaffirmation, I-10)

Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers H-100.950
1. Our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system.
2. Our AMA supports requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays.
3. Our AMA will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs. (Res. 809, I-16)

Food and Drug Administration H-100.980
(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible. (2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency’s ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate. (Sub. Res. 548, A-92; BOT Rep. 32, A-95; BOT Rep. 32, A-95; BOT Rep. 18, A-96; Reaffirmed: BOT Rep. 7, I-01; Reaffirmation I-07; Reaffirmed: Sub. Res. 504, A-10; Reaffirmation A-15; Reaffirmed: CMS Rep. 06, I-16)
Whereas, The resolution that passed at Interim 2016 lacked the word “diagnosis” and this is also an important aspect of emergent communicable diseases; and

Whereas, Some individuals in the diagnostic fields such as pathology and radiology felt at the last meeting that this was an important addition, but did not make it up to the microphone in time by no fault of anyone in particular; and

Whereas, There were numerous changes made to the original resolution by the reference committee and on the Assembly floor which added to the difficulty of making this necessary edit during Interim 2016; and

Whereas, There is a process to allow amendment of the resolution to accommodate this important aspect of patient care, and it was advised at the last meeting, if desired, to do so at A-17 since the current form had already passed; and

Whereas, A crucial step in being able to prevent, treat, and control newly identified communicable diseases involves first having the ability to diagnose them; therefore be it

RESOLVED, That our AMA-RFS amend RFS policy 410.030R by addition to read as follows:

410.030R  Emergent Communicable Disease Public Health Crises: That our RFS support AMA efforts in urging Congress to expeditiously act to ensure sufficient funding for research, prevention, diagnosis, control, and treatment of newly identified communicable diseases that pose a public health emergency without diverting resources from other essential health initiatives. (Resolution 6, I-16)

Fiscal Note:

References:
1. I-16 RFS Summary of Actions, Resolution 6:
RESOLVED. That our RFS support AMA efforts in urging Congress to expeditiously act to ensure sufficient funding for research, prevention, control, and treatment of newly identified communicable diseases that pose a public health emergency without diverting resources from other essential health initiatives.

Relevant RFS Policy and AMA Policy:

**410.030R Emergent Communicable Disease Public Health Crises**: That our RFS support AMA efforts in urging Congress to expeditiously act to ensure sufficient funding for research, prevention, control, and treatment of newly identified communicable diseases that pose a public health emergency without diverting resources from other essential health initiatives. (Resolution 6, I-16)
Resolved: 3
(A-17)

Introduced by: Ashley Reddy Lentini, MD; Josh Lesko, MD;

Subject: Harmful Effects of Screen Time and Blue Light Exposure in Children

Referred to: Reference Committee

Whereas, Increased screen time amongst youth has been associated with an increase in morbidities such as obesity, sleep problems, depression and anxiety; and

Whereas, Screen time can be utilized for both educational and recreational purposes; and

Whereas, Screens with artificial light, as found in smart phones and tablets, can emit a substantial amount of short-wavelength (blue-enriched) light emissions; and

Whereas, The blue light emitted from screens can lead to disruption of circadian rhythm, as it suppresses melatonin secretion, and enhances alertness which can ultimately impact duration and quality of sleep; therefore be it

RESOLVED, That our AMA encourage all schools to incorporate into health class curriculum the topic of balancing screen time with physical activity and sleep; and be it further

RESOLVED, That the AMA encourage research into the utility of blue light filtering glasses and a blue light filter option on devices such as smart phones and tablets; and be it further

RESOLVED, That our AMA encourage physicians to assess all patients and educate all parents about amount of screen time, physical activity and sleep habits.

Fiscal Note:

References:

Relevant AMA and RFS Policy:
Emotional and Behavioral Effects of Video Game and Internet Overuse D-60.974
Our AMA:
(1) urges agencies such as the Federal Trade Commission as well as national parent and public interest organizations such as the Entertainment Software Rating Board, and parent-teacher organizations to review the current ratings system for accuracy and appropriateness relative to content, and establish an improved ratings systems based on a combined effort from the entertainment industry and peer review;
(2) will work with key stakeholder organizations such as the American Academy of Pediatrics and the American Academy of Family Physicians to (a) educate physicians on the public health risks of media exposure and how to assess media usage in their pediatric populations and (b) provide families with educational materials on the appropriate use of video games;
(3) supports increased awareness of the need for parents to monitor and restrict use of video games and the Internet and encourage increased vigilance in monitoring the content of games purchased and played
for children 17 years old and younger;
(4) encourages organizations such as the Centers for Disease Control and Prevention, the National Science Foundation, and the National Institutes of Health to fund quality research (a) on the long-term beneficial and detrimental effects not only of video games, but use of the Internet by children under 18 years of age; and (b) for the determination of a scientifically-based guideline for total daily or weekly screen time, as appropriate; and
(5) will forward Council on Science and Public Health Report 12-A-07, Emotional and Behavioral Effects of Video Game and Internet Overuse, to the American Psychiatric Association and other appropriate medical specialty societies for review and consideration in conjunction with the upcoming revision of the Diagnostic and Statistical Manual of Mental Disorders. (CSAPH Rep. 12, A-07)

Human and Environmental Effects of Light Emitting Diode (LED) Community Lighting H-135.927
1. Our AMA supports the proper conversion to community-based Light Emitting Diode (LED) lighting, which reduces energy consumption and decreases the use of fossil fuels.
2. Our AMA encourages minimizing and controlling blue-rich environmental lighting by using the lowest emission of blue light possible to reduce glare.
3. Our AMA encourages the use of 3000K or lower lighting for outdoor installations such as roadways. All LED lighting should be properly shielded to minimize glare and detrimental human and environmental effects, and consideration should be given to utilize the ability of LED lighting to be dimmed for off-peak time periods. (CSAPH Rep. 02, A-16)
AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 4
(A-17)

Introduced by: Jason Woloski, MD; Ashley Reddy Lentini, MD; Josh Lesko, MD; Prajwal Ciryam, MD; Hasan Iftikhar, MD

Subject: Education on, Screening, and Reporting of Elder Abuse and Neglect

Referred to: Reference Committee

Whereas, Elder abuse and neglect has been identified as a public health problem, with estimates ranging between 4-10% of individuals greater than age 65; and

Whereas, Studies have found that elderly living at home may be more likely to suffer forms of abuse and may also be more likely to be living with the perpetrator; and

Whereas, Elder abuse is a complex topic and can involve neglect, psychological abuse, financial abuse, and physical abuse; and

Whereas, Elder neglect and abuse have many clinical presentations, ranging from obvious bruises and fractures to the subtle appearance of dehydration, depression, and apathy; and

Whereas, Elder abuse is associated with significant morbidity and early mortality; and

Whereas, Elder abuse has also been associated with depression, decreased control of chronic conditions, and functional disability; and

Whereas, Fiscal costs related to elder abuse and neglect are profound, with direct medical costs associated with violent injuries to older adults estimated to add over $5.3 billion to the nation’s annual health expenditures, while annual financial losses by victims of elder financial exploitation were estimated to be $2.9 billion in 2009; and

Whereas, Studies have not clearly shown what interventions would be most helpful to prevent elder abuse and increase knowledge regarding screening for neglect, abuse, and exploitation; and

Whereas, Only a fraction of the incidents are appropriately reported; and

Whereas, It is has been estimated that more than 80 percent of elder abuse cases fail to get reported by older adults because of shame, self-blame, fear of reprisal or loss of independence, not knowing their rights, or not knowing where or how to get help; and

Whereas, The percentage of adults 65 years of age and older in the U.S. is estimated to dramatically increase from current levels of less than 15% of the population to nearly 22% by 2060; and

Whereas, Less than two percent of Adult Protective Service reports are filed by physicians; and
Whereas, Physicians detect and report elder abuse infrequently despite its widespread prevalence; and

Whereas, Many physicians are unaware of the correct prevalence and risks related to elder abuse and/or neglect; therefore be it

RESOLVED, That our AMA promote elder abuse screening during patient encounters when deemed appropriate by the provider; and be it further

RESOLVED, That our AMA promote research to ascertain if the use of educational programs and interventions improves attitude and knowledge of all caregivers and ultimately leads to the reduction of elder abuse incidents.

Fiscal Note:

References:

Relevant AMA and RFS Policy:

Elder Mistreatment D-515.985
1. Encourages all physicians caring for the elderly to become more proactive in recognizing and treating vulnerable elders who may be victims of mistreatment through prevention and early identification of risk factors in all care settings. Encourage physicians to participate in medical case management and APS teams and assume greater roles as medical advisors to APS services.
2. Promotes collaboration with the Liaison Committee on Medical Education and the Association of American Medical Colleges, as well as the Commission on Osteopathic College Accreditation and American Association of Colleges of Osteopathic Medicine, in establishing training in elder mistreatment for all medical students; such training could be accomplished by local arrangements with the state APS teams to provide student rotations on their teams. Physician responsibility in cases of elder mistreatment could be part of the educational curriculum on professionalism and incorporated into questions on the US Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination.
3. Encourages the development of curricula at the residency level and collaboration with residency review committees, the Accreditation Council for Graduate Medical Education, specialty boards, and Maintenance of Certification programs on the recognition of elder mistreatment and appropriate referrals and treatment.
4. Encourages substantially more research in the area of elder mistreatment.
5. Encourages the US Department of Health and Human Services, Office of Human Research Protections, which provides oversight for institutional review boards, and the Association for the Accreditation of Human Research Protection Programs to collaborate on establishing guidelines and protocols to address the issue of vulnerable subjects and research subject surrogates, so that research in the area of elder mistreatment can proceed.
6. Encourages a national effort to reach consensus on elder mistreatment definitions and rigorous
objective measurements so that interventions and outcomes of treatment can be evaluated.

7. Encourages adoption of legislation, such as the Elder Justice Act, that promotes clinical, research, and educational programs in the prevention, detection, treatment, and intervention of elder abuse, neglect, and exploitation. (CSAPH Rep. 7, A-08; Reaffirmed: CMS Rep. 8, I-13)

**Elder Mistreatment H-515.961**

Our AMA recognizes: (1) elder mistreatment as a serious and pervasive public health problem that requires an organized effort from physicians and all medical professionals to improve the timely recognition and provision of clinical care in vulnerable elders who experience mistreatment; and (2) the importance of an interdisciplinary and collaborative approach to this issue, and encourage states to bring together teams with representatives from medicine, nursing, social work, adult protective services (APS), criminal and civil law, and law enforcement to develop appropriate interventions and evaluate their effectiveness. (CSAPH Rep. 7, A-08)

**Family and Intimate Partner Violence H-515.965**

(1) Our AMA believes that all forms of family and intimate partner violence are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of victims. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society. Our AMA's efforts will be guided, in part, by its Advisory Council on Family Violence.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula when developed. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist victims. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter victims on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to:

(a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care;

(b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course;

(c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible;

(d) Have written lists of resources available for victims of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid;

(e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence;

(f) Become aware of local resources and referral sources that have expertise in dealing with trauma from victimization;

(g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either victims or abusers themselves;

(h) Give due validation to the experience of victimization and of observed symptomatology as possible
sequelae;
(i) Record a patient's victimization history, observed traumata potentially linked to the victimization, and referrals made;
(j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level;

(4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
(b) Believes it is critically important that programs be available for victims and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult victims of intimate partner violence if the required reports identify victims. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of victims' identities;
(b) allow competent adult victims to opt out of the reporting system if identifiers are required;
(c) provide that reports be made to public health agencies for surveillance purposes only;
(d) contain a sunset mechanism; and
(e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:
(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.
(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.
(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.
(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.
(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. (CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep 2, I-09)
Whereas, AMA-RFS policy 580.013R instructs that our Section develop a mechanism to sunset RFS policy after ten years unless positive action to retain the policy is taken; and

Whereas, AMA policy in G-600.110 describes a sunset mechanism outside of Bylaws in which the following outcomes are delineated:

(i) Retain the policy
(ii) Sunset the policy
(iii) Retain part of the policy
(iv) Reconcile the policy with more recent and like policy; and

Whereas, Other professional medical organizations, such as the Massachusetts Medical Society, have adopted sunset mechanisms that allow more nimble handling of existing policy, including the ability to retain or sunset independent sections of policies, as well as amendment processes for policies which address both editorial and substantive changes; and

Whereas, AMA-RFS internal sunset practices have been an all-or-nothing process, precluding thoughtful handling of complex policies such as 555.997R with obsolescence of some but not all clauses; and

Whereas, Directives further outlining the RFS sunset mechanism are currently not included in policies or Internal Operating Procedures; therefore be it

RESOLVED, That our AMA-RFS Governing Council present actionable sunset recommendations to RFS policy via a yearly report at our Annual Meeting; and be it further

RESOLVED, That each adopted resolve or recommendation clause within an RFS policy shall be considered individually with regard to the sunsetting process; and be it further

RESOLVED, That our AMA-RFS annually review ten-year-old RFS policies and recommend whether to (a) reaffirm the policy, (b) rescind the policy, (c) reconcile the policy with more recent and like policy, or (d) make editorial changes which maintain the original intent of the policy; and be it further

RESOLVED, That each RFS sunset recommendation regarding RFS policy may be extracted from the Consent Calendar and handled individually by our Assembly, but may only be adopted or not adopted; and be it further

RESOLVED, That an action of the RFS Assembly that retains or updates an existing RFS policy shall reset the sunset “clock,” making the reaffirmed RFS policy viable for ten additional years; and be it further
RESOLVED, That defeated RFS sunset recommendations be reaffirmed for one year, to be readdressed via RFS Governing Council report or resolution from the RFS Assembly at or prior to the next RFS Annual Meeting; and be it further

RESOLVED, That nothing in this policy shall prohibit a report or resolution to sunset an RFS policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current RFS policy, or has been accomplished; and be it further

RESOLVED, That 580.013R Sunset of AMA-RFS Policy be rescinded.

Fiscal Note: Minimal

References:

Relevant RFS Policy and AMA Policy:

580.013R: Sunset of AMA-RFS Policy
That the AMA-RFS develop a mechanism to sunset AMA-RFS policy after ten years unless positive action to retain the policy is taken. (Report H, I-85) (Reaffirmed Report C, I-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

G-600.110: Sunset Mechanism for AMA Policy
1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.
3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.
4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.
5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
6. Sunset policies will be retained in the AMA historical archives.
Whereas, Our AMA-RFS adopted Governing Council Report B: AMA-RFS Caucus Structure and Function (A-15), which allowed for the RFS Caucus of Sectional Delegates to the HOD to make ad hoc decisions via 2/3rds vote on behalf of the Section and its Assembly; and

Whereas, These changes in the RFS Internal Operating Procedures (IOPs) were reviewed by our AMA-Council on Constitution and Bylaws and became effective in April 2016; and

Whereas, Section C of the updated bylaws describes a reporting responsibility by the Governing Council Delegates:

C. Reporting of Caucus Actions

1. The RFS Delegate and Alternate shall be responsible for authoring a report of actions taken, which shall be presented to the RFS Assembly at the next national meeting. This report will list the resolved clauses of all AMA HOD resolutions for which the RFS took a position, and will specifically identify those resolutions for which the RFS Caucus took a position that was not grounded in existing internal policy. It will also detail the action taken, motivation for taking such action, and suggestions for new AMA-RFS policy on the issue in question. (emphasis added); and

Whereas, Our Governing Council has since I-16 interpreted this language as to require an informational Delegates’ Report with topic area suggestions for future resolutions with a system of informal requests that resolutions be drafted by Sectional Delegates as individuals to be considered as de novo submissions; and

Whereas, Our RFS Caucus took several caucus votes at the I-16 meeting which were not disseminated to the RFS Assembly at large by the time of the April 10, 2017 resolution deadline, with specific issues including:

1. Principles related to AMA support of the Patient Protection and Affordable Care Act (Late Resolution 223)
2. Needle and syringe disposal (Resolution 912)
3. Youth incarceration in adult prisons (Resolution 917)
4. Support for DACA-eligible healthcare professionals (Emergency Resolution 1001); and

Whereas, Topic area suggestions via Delegates’ Report will always be published too late to allow non-sectional delegate authors to meet AMA-RFS resolution filing deadlines at the following meeting; and

Whereas, It appears that at the regular resolution deadline of April 10, 2017, these topics will not have been introduced in actionable form either through Governing Council report or commissioned resolution; therefore be it

Resolution: 6 (A-17)
RESOLVED, That our AMA-RFS limit support of health system reform proposals to those which include:

1. Guaranteed insurability, including those with pre-existing conditions, without medical underwriting
2. Income-dependent tax credits to subsidize private health insurance for eligible patients
3. Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979)
4. Maintaining dependents on family insurance plans until the age of 26
5. Coverage for preventive health services
6. Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs; and be it further

RESOLVED, That our AMA-RFS support safe design, storage, and disposal requirements for medical needles and syringes; and be it further

RESOLVED, That our AMA-RFS support needle exchange programs in communities with IV drug abuse problems; and be it further

RESOLVED, That our AMA-RFS advocate against the incarceration of children under the age of 18 in adult prisons for non-violent crimes; and be it further

RESOLVED, That our AMA-RFS support early intervention and rehabilitation of children under the age of 18 who have been incarcerated in adult prisons; and be it further

RESOLVED, That our AMA-RFS support maintenance of current legal status for current US physicians and medical students who are Deferred Action for Childhood Arrivals (DACA) recipients; and be it further

RESOLVED, That prior to I-17, our Governing Council will develop a mechanism to educate the RFS Assembly at large on the ad hoc policy actions of the RFS Caucus as to allow related resolutions to be written within existing deadlines; and be it further

RESOLVED, That our Governing Council be ultimately responsible for introducing business to cover ad hoc policy actions of the RFS Caucus not addressed by a resolution at the meeting of the RFS Assembly immediately following the meeting of the AMA HOD where ad hoc policy positions were crafted.

Fiscal Note: Minimal

References:

Relevant RFS Policy and AMA Policy:
WHEREAS, Gun violence is a major public health problem, with firearms involved in the deaths of 33,599 people in the U.S in 2014, including homicides, suicides, and unintentional deaths, which accounted for 16.8% of the injury deaths that year; and

WHEREAS, Gun violence costs the country approximately $229 billion annually, including 8.6 billion in direct expenses such as emergency and medical care; and

WHEREAS, the AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country; therefore be it

RESOLVED, That our AMA-RFS supports legislation to require anyone who purchases a firearm to wait at least one week before taking delivery of the firearm; and be it further

RESOLVED, That our AMA-RFS supports expansion of the Brady Handgun Violence Protection Act of 1998, to require background checks for all firearms purchasers including sales by gun dealers, sales at gun shows, sales made online, and private gun transfers between individuals; and be it further

RESOLVED, That our AMA-RFS supports state legislation to mandate universal background checks, either as part of a permit to purchase licensing system for all gun sales, or by mandating universal background checks in the absence of a permit law.

Fiscal Note:

References:

Relevant RFS Policy and AMA Policy:

110.001R Firearm Background Checks: That our AMA-RFS (1) advocates a waiting period and background check for all firearm purchasers; (2) encourages state and federal legislation that enforces a waiting period for all transactions, background check for all purchasers during firearm transactions; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. (Resolution 9, A-16)

Control of Non-Detectable Firearms H-145.994
The AMA supports a ban on the manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices. (Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

Gun Control H-145.991
The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country. (Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)

Gun Regulation H-145.999
Our AMA supports stricter enforcement of present federal and state gun control legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm. (Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07)

Waiting Period Before Gun Purchase H-145.992
The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S. (Res. 171, A-89; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)

Firearm Availability H-145.996
Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers; (2) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. (Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16)
Resolved: 8

(A-17)

Introduced by: Joseph Lee, MD; Amy Brown, MD

Subject: Financial Protections for Doctors in Training

Referred to: Reference Committee

Whereas, The AMA has guidelines that expect all institutions to provide retirement benefits; and
Whereas, With Resident and Fellowship Matching, physicians do not have choice in the benefit package causing differences in retirement outcomes; and
Whereas, Physicians should be saving 15% of their funding towards retirements, but studies have shown that physicians have not been saving enough due to multiple reason including significant student debt, delayed start in professional life, and decreased financial literacy\(^2,3\); and
Whereas, Evidence has shown that employers who match retirement savings, result in employees saving significantly more annual for retirement\(^4\); therefore be it
RESOLVED, That our AMA support retirement plans for all residents and fellows, which includes retirement plan matching in order to further secure the financial stability of physicians and increase financial literacy during training; and be it further
RESOLVED, That our AMA support that all programs provide financial advising to resident and fellows.

Fiscal Note:

References:
3. https://www.mededpublish.org/manuscripts/847/v1

Relevant RFS Policy and AMA Policy:

310.799R Benefit Packages for Resident Physicians: Resolved (1) that the AMA-RFS seek to assure that all institutions be required to provide their resident physicians with disability insurance, life insurance, HIV indemnity, malpractice insurance including tail coverage, retirement benefits, health, sick leave and wages commensurate with their education and experience; and (2) if a given benefit or salary is provided to some residents within a given program at the same postgraduate level, then that benefit must be provided to all residents. However, this provision cannot be used to eliminate the benefit in question. (Substitute Resolution 13, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-12)
Whereas, Recent data from the American Academy of Pediatrics has shown liquid laundry detergent packets (pods) are more dangerous to children than other types and forms of detergent; and

Whereas, Accidental exposures of children age 6 and under to the toxic contents of liquid laundry detergent packets increased 17% from 2013 to 2014; and

Whereas, Of children accidentally exposed to the contents of liquid laundry detergent packets, approximately 43.5% experience at least one clinical effect (1). Such effects include vomiting, coma, respiratory arrest, pulmonary edema, throat burns, and eye injuries; and

Whereas, In 2014, the American Society for Testing and Materials International (ASTM) adopted the first safety standard for packaging and labeling of liquid laundry detergent packets. Such standards call on manufacturers to voluntarily place warning labels on the front and back of packaging, add a bitter taste to the soluble film encasing the detergent to deter children from putting packets in their mouths, make the film encasing packets take longer to dissolve once wet, and making containers of packets harder to open; therefore be it

RESOLVED, That our AMA support the ASTM International safety standards for liquid laundry detergent packets; and be it further

RESOLVED, That our AMA further study the safety of liquid laundry detergent packets and the potential clinical risk they pose to children; and be it further

RESOLVED, That our AMA promote increased education for parents and caregivers regarding the safe storage and use of liquid laundry detergent packets around children.

Fiscal Note:

References:
Relevant RFS Policy and AMA Policy:

Support for Detergent Poisoning and Child Safety Act D-60.967
1. Our AMA will advocate to the state and federal authorities for laws that would protect children from poisoning by detergent packet products by requiring that these products meet child-resistant packaging requirements and that these products are manufactured to be less attractive to children in color and in design and to include conspicuous warning labels.
2. Our AMA will advocate that the detergent product package labeling be constructed in a clear and obvious method so children know that the product is dangerous to ingest. (Res. 430, A-16)
Whereas, Inequalities in determinants of health and health outcomes continue to exist, with the color of a patient’s skin determining, at least in part, the quality of their health care; and

Whereas, Some of these disparities are due to differential treatment and care by physicians; and

Whereas, An ever-increasing number of patients in the United States identify as a member of a minority group, including approximately 38% of the current population; and

Whereas, Recognition of implicit bias and training in diversity and inclusion may mitigate both intentional and unintentional disparities in the provision of care to minority patients; and

Whereas, Reducing disparities requires national leadership to coordinate thoughtful, intentional action by leaders at each medical school and residency training program; therefore be it

RESOLVED, That our AMA will:

(1) Actively support the development and implementation of training implicit bias, diversity and inclusion as a component of medical education in all medical schools and residency programs;

(2) Identify and publicize effective strategies for educating residents in all specialties about disparities in their fields according to race and ethnicity, with particular regard to access to care and health outcomes; and

(3) Support research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes according to race and ethnicity.

Fiscal Note:

References:


**Relevant RFS Policy and AMA Policy:**

**350.002R Increasing Diversity in the Medical Profession:** That our AMA-RFS: (1) encourage its members to participate in mentoring and role-modeling programs such as the AMA MAC’s Doctors Back to School Program in order to attract more underrepresented minority students towards the medical profession, and (2) support efforts to eliminate racial and ethnic health care disparities. (Resolution 6, I-03) (Reaffirmed Report D, I-13)

**Strategies for Enhancing Diversity in the Physician Workforce D-200.985**

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups. 2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas. 3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. 4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty. (CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16)

**Reducing Racial and Ethnic Disparities in Health Care D-350.995**

Our AMA’s initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

1. Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
2. Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities. (BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation A-16)

Diversity in the Physician Workforce and Access to Care D-200.982
Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting. (CME Rep. 7, A-08; Reaffirmation A-13; Reaffirmation A-16)
Whereas, It has been documented that physician participation during in-flight medical emergencies occurred during 48.1% of the 1,920 cases reviewed; and

Whereas, There is no standardized system in place for accurate data collection of in-flight medical emergencies and current data is collected by airline surveys and data from emergency call centers and thus affected by reporting bias; and

Whereas, There is no current policy in place for rapid identification of healthcare professionals willing to assist during in-flight medical emergencies and identification of medical professionals during in-flight medical emergencies is currently done by overhead announcement; and

Whereas, There is no current policy in place to verify the credentials of volunteer medical professionals during or prior to in-flight medical emergencies; and

Whereas, Existing AMA policy supports legislative provisions that provide legal and personal protections who choose to provide medical care during in-flight medical emergencies with AMA policy H-45.997 stating, “Our AMA supports legislative provisions that grant any physician, other medical professional, or airline employee, acting in the role of a Good Samaritan during an in-flight medical emergency, an umbrella of immunity against legal or personal redress by the airline, the passengers, or the persons involved in the medical emergency.”; therefore be it

RESOLVED, That our AMA work directly with the Federal Aviation Authority to design a system-wide process to volunteer in advance of in-flight medical emergencies using the National Provider Identifier number as a means of verification during flight booking and check-in; and be it further

RESOLVED, That our AMA support efforts to improve data collection on in-flight medical emergencies to further direct and improve care during these situations; and be it further

RESOLVED, That our AMA oppose policy obligating physician participation during in-flight medical emergencies; and be it further

RESOLVED, That our AMA continue to support legislative provisions protecting physicians and other medical professionals acting in the role of a Good Samaritan during an in-flight medical emergency.

Fiscal Note:

References:


Relevant RFS Policy and AMA Policy:

90.002R Improvement in US Airlines Aircraft Emergency Kits: That our AMA (1) encourage the FAA to report on medical emergencies that occur in US air carrier domestic and international flights; and (2) review the content of US air carriers airline emergency kits and recommend appropriate upgrades of these kits. (Substitute Resolution 17, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

90.003R Emergency Medical Skills Training in Medical Education: Asked that our AMA-RFS support the proposition that a formal emergency medicine experience including didactic and clinical training in basic skills should be a part of undergraduate medical education. (Resolution 8, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

Improvement in US Airlines Aircraft Emergency Kits H-45.981
Our AMA urges federal action to require all US air carriers to report data on in-flight medical emergencies, specific uses of in-flight medical kits and emergency lifesaving devices, and unscheduled diversions due to in-flight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of in-flight medical emergencies and issue recommendations regarding the contents of in-flight medical kits and the use of emergency lifesaving devices aboard commercial aircraft. (Res. 507, A-97; Amended: CSA Rep. 3, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of: Res. 502, A-16)

In-Flight Emergency Care H-45.997
Our AMA supports legislative provisions that grant any physician, other medical professional, or airline employee, acting in the role of a Good Samaritan during an in-flight medical emergency, an umbrella of immunity against legal or personal redress by the airline, the passengers, or the persons involved in the medical emergency. (BOT Rep. S, I-83; CLRPD Rep. 1, I-93; Reaffirmed by Sub. Res. 201, I-96; Amended: CSA Rep. 3, I-99)

In-flight Medical Emergencies H-45.978
Our AMA urges: (1) urges that decisions to expand the contents of in-flight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; in-flight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements; and (2) the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive in-flight emergency medical systems that ensure: (a) rapid 24-hour access to qualified emergency medical personnel on the ground; (b) at a minimum, voice communication with qualified ground-based emergency personnel; (c) written protocols, guidelines, algorithms, and procedures for responding to in-flight medical emergencies; (d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form; (e) adequate medical supplies and equipment aboard aircraft; (f) routine flight crew safety training; (g) periodic assessment of system quality and effectiveness; and (h) direct supervision by physicians with appropriate training in emergency and aerospace medicine. (CSA Rep. 3, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation I-14; Reaffirmed in lieu of: Res. 502, A-16)
Air Travel Safety H-45.979
Our AMA: (1) encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies; (2) encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an in-flight medical emergency; and (3) will support efforts to educate the flying physician public about in-flight medical emergencies (IFMEs) to help them participate more fully and effectively when an IFME occurs, and such educational course will be made available online as a webinar. (CSA Rep. 5, I-98; Appended: CSA Rep. 3, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-14; Reaffirmation I-14; Reaffirmed in lieu of Res. 503, A-15; Reaffirmed in lieu of: Res. 502, A-16)
Introduction
At the 2015 Interim Meeting of the American Medical Association Resident and Fellow Section (AMA-RFS), the Assembly considered and elected to not adopt Governing Council Report E, titled "One Endorsee Is Enough," which was written in response to the 2014 RFS Annual Meeting Resolution 1 by the same title authored by individuals from Massachusetts, Pennsylvania, and Michigan. Report E had recommended a maximum of one endorsee to the positions of Resident/Fellow member of the Board of Trustees as well as to the Resident/Fellow seats on AMA non-appointed Councils.

This issue of multiple endorsements was revisited at I-16 during contested endorsement contests for the Resident/Fellow seats on the Board of Trustees (BoT) and the Council on Science and Public Health (CSAPH). Based on the Speakers’ interpretation of the AMA-RFS Internal Operating Procedures (IOPs), the Assembly was instructed to first decide whether multiple endorsements were to be allowed prior to the endorsement votes themselves. The issue of multiple endorsements will be discussed in section 1 of this report.

Separately, there was a question of duration of an RFS endorsement in the context of multiple endorsements; may a previously-endorsed candidate claim RFS endorsement for subsequent election cycles, contested or not? At present time, there are no relevant internal policies or specific actions from the AMA-RFS that have pertained to the expiration of specific endorsements from societies or organizations. The issue of expiration of endorsements will be discussed in section 2 of this report.

Finally, there was a question of whether or not RFS members should be able to hold more than one elected position at once, such as simultaneously serving on the RFS Governing Council as well as on AMA Councils as the Resident/Fellow member. Per review of our Internal Operating Procedures, it is unclear if members can hold more than one council position at the same time. Furthermore, due to time constraints and often conflicting commitments at national meetings, it is uncertain if one RFS member can adequately fulfill holding more than one council position.

The issue of holding multiple council positions will be discussed in section 3 of this report. In this context, the AMA-RFS Governing Council has charged the RFS Committee on Long Range Planning to re-examine the RFS external endorsement process and appropriateness of candidates simultaneously serving in multiple leadership positions. This report provides background on existing AMA-RFS IOPs, reviews recent history of RFS elections, compares the
election processes of other delineated sections and House of Delegates (HOD) caucuses, and makes recommendations for changes to the AMA-RFS IOPs.

Discussion

Section 1: Multiple Endorsements
Current IOPs of our AMA-RFS provide for the opportunity to endorse multiple candidates for the position of AMA-RFS Trustee as well as for each AMA-RFS seat on AMA councils. The relevant IOP’s are as below:

VII.D.2,5 (Endorsement of Resident and Fellow Trustee.Endorsement Process):
2. Method of Endorsement. Where there is only one candidate, endorsement may be by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall be in order. Endorsements shall be by ballot. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no ranking, and it should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed.

5. Late Endorsement. A candidate may ask for endorsement by the Assembly at the annual meeting of the Assembly. This is subject to the same rules described above and additionally requires a 2/3 vote of the Assembly for endorsement. In the case of an individual seeking late endorsement, any individual who has already been endorsed for the position shall be allotted equal time before the Assembly and shall have his or her materials reprinted in the Assembly handbook upon request.

VIII.D.2,4 (Endorsement of Candidates for Elected AMA Councils.Endorsement Process):
2. Method of Endorsement. Where there is only one candidate for a given council, endorsement may be by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall be in order. Endorsements shall be by ballot. There shall be a separate ballot for each Council. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no ranking, and it should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed.

4. Late Endorsement. A candidate may ask for endorsement by the Assembly at the Annual Meeting of the Assembly. This is subject to the same rules described above and additionally requires a 2/3 vote of the Assembly for endorsement. In the case of an individual seeking late endorsement, any individual who has already been endorsed for the position shall be allotted equal time before the Assembly and shall have his or her materials reprinted in the Assembly handbook upon request.

What was in question at I-16 was whether the excerpts in bold direct optional votes be taken to endorse multiple candidates, or whether it simply allows multiple motions to endorse multiple candidates. Ultimately, the Speakers chose to establish precedent by interpreting the question in the former, and entertained motions for multiple endorsements prior to opening of speeches and balloting.

Suitability of multiple endorsements
Regardless of the ambiguity of the aforementioned language, Resolution 1 (A-14) and the resulting Report E (I-15) proposed a change to the IOPs in an attempt to simplify the
endorsement process and allow only one endorsee for the position of AMA-RFS Trustee and each AMA-RFS non-appointed seat on AMA committees and councils. Ultimately, these recommendations, which required at 2/3rd + 1 majority for a change to IOPs, was not adopted by the assembly.

The I-15 Reference Committee recommended non-adoption on the grounds that “multiple strong candidates campaigning in the HOD improved the standing of the RFS.” It also argued that “a competitive campaign between RFS endorsed candidates also strengthened the candidates’ knowledge and experience of the AMA and increased their credibility within the HOD.” In contrast, the endorsement contests of I-16 was notable for decisions of the Assembly that contradicted these positions: 1) In a contest among five candidates for CSAPH endorsement, the Assembly voted against endorsing more than one candidate; 2) In a contest between three candidates for BOT, the Assembly affirmatively voted for the opportunity for multiple candidates, but did not do so, endorsing only one. Ultimately two of the candidates submitted notices of candidacy for the HOD-level election for Resident/Fellow seat on the BOT.

In the context of these real-world decisions, CLRP has elected to re-examine this process. Salient points in Report E (I-15) included consistency with practices among other AMA sections, sections, specialty societies and sections, and geographic caucuses within the HOD, as review of bylaws from these groups demonstrated a near-consensus against endorsing more candidates than there are positions.

For example, the AMA-Medical Student Section (MSS) and Young Physicians Section (YPS) each endorse only one candidate. AMA-MSS VII.D.6.b describes a series of run-offs to elect the nominee for Medical Student Member of the Board of Trustees. In practice, this position is directly elected by the MSS Assembly. AMA-YPS nominations are selected by its Governing Council with stipulation that they will “endorse no more than the available positions on the Council or Board.” Subsequent to the report, the only Section or Caucus which allowed additional endorsements was the AMA Specialty and Service Society (SSS), on the grounds that their group cast such a wide net that included non-HOD organizations that single-endorsements might be unnecessarily limiting.

Report E (I-15) further argued that multiple endorsements by RFS for a single position could potentially harm any AMA-RFS candidate as well as the AMA-RFS section as a whole, specifically noting a potential signal that the AMA-RFS is not capable of evaluating or assessing candidates to determine the best individual for a single position and deferring a decision to an external body. It further noted that while RFS endorsement does not guarantee election, having only one candidate endorsed by the RFS would likely strengthen not only the Resident/Fellow voice but also the specific endorsee’s credentials for the position.

Your CLRP notes that failure to secure RFS endorsement does not preclude a candidate from advancing his/her candidacy to the HOD. A potential benefit of processes in which more than one candidate seek election at the HOD level is the need for multiple candidates to campaign and network more vigorously in the HOD. Multiple candidates would need to network with their state and specialty societies more earnestly which could promote greater involvement for candidates at various levels within organized medicine as well as greater recognition of the issues important to the RFS. Arguably, this may facilitate the development of better candidates, ultimately benefitting the organization. However, as the upcoming election for Resident/Fellow seat on the BOT demonstrates, multiple RFS endorsements are not needed for this competitive HOD election.
Barring a significant confounding circumstance, the single endorsee by AMA-RFS would have a clearer path to confirmation and election by the HOD, as the unendorsed candidate would have to answer why he or she was not endorsed by the group he/she aims to represent. That the unendorsed candidate would face electoral disadvantages is actually a desirable consequence of a single-endorsement system, as it would increase the decision-making stakes of the RFS Assembly.

**Conclusion**

The RFS mechanism for multiple endorsements to single positions is currently unusual in comparison to most other AMA Sections and Caucuses. This mechanism has been subject to internal discussion on both process and underlying philosophy.

First, CLRP finds that the Speakers’ interpretation of existing IOP election rules at I-16 to require an optional motion for multiple endorsement was correct based on a close reading of our IOPs and our parliamentary authority.

Further, CLRP again recommends formal amendments to IOPs which would limit endorsements of candidates to the Resident/Fellow seats on the BOT and non-appointed councils to a single candidate. This process of endorsing only one candidate is most common among other AMA Sections and Caucuses, and having a parallel process demonstrates cooperation within the AMA and promotes more seamless transitions as our members move forward from the RFS to the AMA-HOD.

Ultimately, in identifying a single endorsee for a position, the RFS would demonstrate that it has thoroughly evaluated and assessed all candidates, that it is capable of selecting a single candidate that best represents the RFS, that it is willing to consolidate its political capital behind an individual candidate, and through this rigorous selection process, it has endorsed the candidate whom it believes is capable of best speaking for the interests of the RFS. *This process would not preclude an unendorsed candidate from seeking election at the HOD level.*

This proposed change of our IOPs would align our section’s endorsement process with other prominent sections within the House of Delegates (HOD) and demonstrate unity within the RFS by selecting the one most favorable candidate for endorsement. These changes are in the best interest of the RFS as they further strengthen the voice and political weight of the section.

Endorsing only one candidate shows unity among the RFS by allowing our section to carefully vet and select the most qualified candidate whom we believe will best represent the interests of our section. Therefore, the RFS Committee on Long Range Planning again proposes changing our IOPs to allow for only one endorsement for positions that represent the RFS within the AMA, thus paralleling the IOPs of other prominent sections within the HOD.

**Section 2: Expiration of Endorsements**

On recent review of the IOPs regarding candidates from the AMA-RFS section seeking out endorsements for various election positions, the question of whether endorsements specifically ‘expire’ has recently arisen. In recent years, events have required candidates to run for the same position or even different positions during several different meetings. The question of whether specific nominations expire is one that is of great relevance to the section. Specifically, is it possible that a previously endorsed candidate from the RFS have their endorsement expire, and if so, what is this standard?
In this context, the AMA-RFS Committee on Long Range Planning has reviewed relevant literature including IOPs and RFS-specific Digest of Actions and found that there are no specific policies concerning the expiration of specific endorsements. This report explores these issues, and makes recommendations for changes to the AMA-RFS IOPs.

Current IOPs of our AMA-RFS do outline specific opportunities for endorsements- among those mentioned and previously detailed are the for multiple candidates to run for the position of AMA-RFS Trustee as well as for each AMA-RFS seat on AMA councils.

Review of bylaws pertaining to endorsement procedures among delineated sections such as AMA-RFS, as well as geographical HOD Caucuses, do not indicate any specific policies regarding the timeframe for endorsements being valid, and whether they specifically expire after an allotted time frame.

While current AMA-RFS IOP provide the opportunity for candidates to run for positions if they are endorsed by their state or specialty society, endorsements not having a specific expiration date could potentially be harmful to AMA-RFS candidates as well the AMA-RFS as a whole. While it has not arisen, a situation could develop where a candidate may continue to use the endorsement of a society or state that may feel that another candidate is more suitable for the role or that the current candidate is not the most suitable person for this position. This sort of miscommunication could harm a specific campaign and also potentially influence the strength of the AMA-RFS within the larger AMA-HOD.

Even within the AMA-RFS itself, the potential arises for a candidate to be elected that does not best represent the RFS itself as policy allows any AMA-RFS member to run for positions in the AMA-HOD without endorsement from the AMA-RFS. This would be further complicated by an outdated or unclear endorsement, of which is needed from society or specialty organization by 30 days following elections as required specifically for candidacy for Sectional Delegates and Alternate Delegates to the HOD.

**Conclusion**

Ultimately, in identifying specific expiration dates for candidates from specialty organizations or societies, the RFS would demonstrate that candidates selected represent the RFS and that the RFS Assembly is able to appropriately consolidate behind a candidate that still maintains approval from their respective organizations.

This proposed change of the IOPs would align the RFS endorsement process with other prominent sections within the House of Delegates, while also creating an environment where it is clear that candidates still have the endorsement without any question of the specific timeframe in which it was obtained.

Therefore, the RFS Committee on Long Range Planning proposes changing our IOPs to allow for endorsements to have a specific time frame of one year (ie: an endorsement obtained for Interim 2016 would not be valid during the Interim 2017 meeting), so that the RFS is better represented within the AMA, and allowing the AMA-RFS to align with other sections of the HOD.

**Section 3: Holding Multiple Leadership Positions**

AMA-RFS has long advocated for mechanisms which allow maximum individuals the opportunity to participate within AMA and AMA-affiliated leadership. Externally, RFS has
unsuccessfully asked that HOD delegates resign their seats when elevated to a position of leadership:

555.997R Refocusing our American Medical Association: (8) That our AMA ensure that all delegates from state and specialty delegations resign membership on their delegations immediately upon appointment or election to any position on a Council, or within the AMA leadership.

Internally, there have been several instances of RFS members who have simultaneously held delegate and council positions. Although there is no prior instance of one resident holding more than one House of Delegates Council position as the Resident/Fellow representative, there are RFS members who have held positions on the RFS Governing Council, HOD Councils, and endorsed positions in national organizations as RFS representatives. These consolidative practices are inconsistent with RFS advocacy on the grounds of wider participation.

The following RFS IOPs and RFS policy address holding multiple positions within the Governing Council:

IOP: V.C.2: Any Governing Council member wishing to be a candidate for a position whose term overlaps with the one he or she is currently serving, must resign his or her current position. Such resignation should be announced prior to the submission deadline for the Governing Council position for which he or she wishes to be a candidate.4


However, the IOPs do not address whether or not a member of an RFS leadership can be endorsed and serve in similarly prestigious Council roles.

Conclusion
Given that our IOPs do not allow members to hold Governing Council positions with overlapping terms, CLRP believes that it is reasonable to apply this to other council positions. Limiting members to holding one position at a time will allow other qualified residents and fellows to become involved in leadership positions within the RFS Section, thus improving the breadth and depth of our section leaders.

RECOMMENDATIONS
With the above discussion, your Committee on Long Range Planning recommendations are as follows:

With respect to the endorsement of the AMA-RFS Trustee and the non-appointed Councils, we recommend the following:

1. AMA-RFS IOP VII.D.2-5 shall be amended by insertion and deletion to read:

2) Method of Endorsement. Where there is a Only one resident or fellow member of the AMA candidate, endorsement may be endorsed by the Resident and Fellow Section (RFS) Assembly to serve as the Resident and Fellow Trustee by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall
be in order. Endorsements shall be by ballot. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no ranking, and it should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed.

3) The AMA-RFS Assembly may endorse a resident or fellow member at the Interim Meeting to be a candidate for a single term. The Assembly may choose not to endorse any candidate for the position of Trustee.

4) Processing. Endorsements shall be by private ballot. No ballots will be cast after the expiration of the voting period. The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the boxes will be sequestered in a private location. At this time the Chair of the Rules Committee will open the ballot box and the Rules Committee will then count the ballots and tabulate the results. Counting shall proceed by counting the number of affirmative votes for each candidate. Every candidate who receives an affirmative vote from greater than 50% of those who cast legal ballots shall be endorsed.

5) The candidate must receive an affirmative vote from greater than 50% of those who cast legal ballots from the AMA-RFS Assembly to be endorsed by the AMA-RFS.

6) As per RFS Internal Operating Procedures V.F.5.b, there shall be a run-off ballot between the two highest vote recipients in the event that no single candidate receives a majority of legal votes cast for a given office.

7) Validating. Upon completion of the tabulation, the Chair of the Rules Committee will validate the election results by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed and will then certify the results in writing. He or she will then immediately forward these results to the Assembly’s presiding officer. The candidate who receives a majority of legal votes cast shall receive complete AMA-RFS endorsement. Upon receipt of the RFS Rules Committee’s election results and verification, the presiding officer will announce the results to the Assembly.

8) Late Endorsement. At the time of the RFS Annual Meeting, if no candidate has been endorsed, a candidate may ask for endorsement by the Assembly at the Annual Meeting of the Assembly. This is subject to the same rules described above and additionally requires a 2/3 vote of the Assembly for endorsement. In the case of an individual seeking late endorsement, any individual who has already been endorsed for the position shall be allotted equal time before the Assembly and shall have his or her materials reprinted in the Assembly handbook upon request.

2. AMA-RFS IOP VIII.D.2-4 shall be amended by insertion and deletion to read:

2) Method of Endorsement: Where there is only one candidate for a given council, endorsement may be by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall be in order. Endorsements shall be by ballot. There shall be a separate ballot for each Council. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no
ranking, and it should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed. Only one resident or fellow member of AMA may be endorsed by the Resident and Fellow Section (RFS) Assembly to serve as a non-appointed Council member.

3) The AMA-RFS Assembly may endorse a resident or fellow member at the Interim Meeting to be a candidate for a single term. The Assembly may choose not to endorse any candidate for the position of non-appointed Council member.

4) 3. Processing. Endorsements shall be by private ballot. No ballots will be cast after the expiration of the voting period. The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the boxes will be sequestered in a private location. At this time the Chair of the Rules Committee will open the ballot box and the Rules Committee will then count the ballots and tabulate the results. Counting shall proceed by counting the number of affirmative votes for each candidate.

5) Every candidate who must receive an affirmative vote from greater than 50% of those who cast legal ballots from the AMA-RFS Assembly to shall be endorsed by the AMA-RFS.

6) As per RFS Internal Operating Procedures V.F.5.b, there shall be a run-off ballot between the 2 highest vote recipients in the event that no one candidate receives a majority of legal votes cast for a given office.

7) The candidate who receives a majority of legal votes cast shall receive complete AMA-RFS endorsement. Upon receipt of the Rules Committee’s election results and verification, the prescribing officer will announce the results to the Assembly.

8) 4. Late Endorsement. At the time of the RFS Annual Meeting, if no candidate has been endorsed, a candidate may ask for endorsement by the AMA-RFS Assembly at the Annual Meeting of the Assembly. This is subject to the same rules described above and additionally requires a 2/3 vote of the Assembly for endorsement. In the case of an individual seeking late endorsement, any individual who has already been endorsed for the position shall be allotted equal time before the Assembly and shall have his or her materials reprinted in the Assembly handbook upon request.

With respect to the timeframe of endorsements and whether they expire, in regard to various positions in AMA-RFS, such as the endorsement of the AMA-RFS Trustee and the non-appointed Councils, we recommend the following:

1. AMA-RFS IOP VII AND VIII shall be amended by insertion to read:

   G. Expiration of Endorsement. Any endorsement of a resident or fellow member, whether endorsed by a specialty society, state society or the RFS Assembly, shall only be valid for two consecutive AMA-RFS Assembly and AMA House of Delegates meetings, which includes the meeting during which the initial endorsement was obtained. If a resident or fellow member is seeking re-endorsement following expiration of previous endorsement, the member would be required to obtain new endorsement for the desired position.
With respect to members holding multiple RFS leadership positions simultaneously, we recommend the following:

1. AMA-RFS IOP V.C.1 shall be amended by insertion to read:
   1) All members of the RFS, including fourth year medical students who have matched into a residency program, are eligible for election to the Governing Council, provided that they do not hold other AMA-RFS Leadership Positions with terms that would overlap with the desired Governing Council position. These AMA-RFS Leadership positions include: RFS Governing Council positions and RFS positions on HOD Councils.

References
1. AMA Resident and Fellow Section. “Endorsement of Resident and Fellow Trustee.” RFS Internal Operating Procedures. 2016:

VII. Endorsement of Resident and Fellow Trustee
Ideally at least one resident or fellow member of AMA shall be endorsed by the RFS Assembly to serve as a member of the Board of Trustees. The AMA-RFS Assembly may endorse a resident or fellow member at the Interim Meeting to be a candidate for a single term. The Assembly may choose not to endorse any candidate for the position of Trustee.

A. Candidates. Resident and fellows seeking endorsement for the Resident/Fellow position on the AMA Board of Trustees must submit an application, curriculum vitae, and statement of interest by the deadline determined by the Governing Council. Incumbent residents seeking reelection may enter the endorsement process if they wish to be re-endorsed. No nominations will be taken from the floor during the Assembly’s business meeting.

B. Speeches. Candidates are allowed to address the Assembly in a manner to be designated by the Speaker. The Speaker shall also design an opportunity for the candidates to respond to questions in front of the general Assembly. The candidates shall be made aware of the format and timing of the address and questions no fewer than 30 days prior to the meeting of the general Assembly.

C. Campaign. Refer to RFS Internal Operating Procedures V.D. for the Code for Campaigning applicable to the Trustee election.

D. Endorsement Process.
   1. Time. The endorsement of the Resident and Fellow Trustee shall occur during the voting period at the Interim Assembly Meeting of the AMA-RFS. The Governing Council shall set the day and time. Candidates may also be endorsed during the Annual meeting by rules outlined below.
   2. Method of Endorsement. Where there is only one candidate, endorsement may be by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall be in order. Endorsements shall be by ballot. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no ranking, and it should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed.
   3. Processing. No ballots will be cast after the expiration of the voting period. The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the boxes will be sequestered in a private location. At this time the Chair of the Rules Committee will open the ballot box and the Rules Committee will then count the ballots and tabulate the results. Counting shall proceed by counting the number of affirmative votes for each candidate. Every candidate who receives an affirmative vote from greater than 50% of those who cast legal ballots shall be endorsed.
4. Validating. Upon completion of the tabulation, the Chair of the Rules Committee will validate the election results by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed and will then certify the results in writing. He or she will then immediately forward these results to the Assembly’s presiding officer. Upon receipt of the Rules Committee’s election results and verification, the presiding officer will announce the results to the Assembly.

5. Late Endorsement. A candidate may ask for endorsement by the Assembly at the annual meeting of the Assembly. This is subject to the same rules described above and additionally requires a 2/3 vote of the Assembly for endorsement. In the case of an individual seeking late endorsement, any individual who has already been endorsed for the position shall be allotted equal time before the Assembly and shall have his or her materials reprinted in the Assembly handbook upon request.

E. Appeals. See RFS Internal Operating Procedures V.F.6.

F. Report to Assembly. The resident or fellow member of the BOT shall submit a written and oral report of the Board’s activities to the Assembly biannually. This report will communicate Board Actions related to the concerns of the RFS and will provide the RFS with directives on behalf of the BOT.

2. AMA Resident and Fellow Section. "Endorsement of Resident and Fellow Trustee.” RFS Internal Operating Procedures. 2016:

VIII. Endorsement of Candidates for Elected AMA Councils
Ideally at least one eligible candidate for each resident/fellow position on elected AMA councils shall be endorsed by the RFS Assembly. These councils are: Council on Medical Service, Council on Medical Education, Council on Constitution and Bylaws, and Council on Science and Public Health. In order to be eligible for endorsement, a candidate must be an AMA member, be a resident or fellow during their term, and formally disclose to voters prior to the endorsement election any portion of their term during which they will not be a resident or fellow. The AMA-RFS Assembly may endorse any, all, or none of the considered eligible candidates.

A. Candidates. Resident and fellows seeking endorsement for the resident position on an AMA Council must submit an application, curriculum vitae, and statement of interest by the deadline determined by the Governing Council in order to be listed in the Assembly handbook. Incumbent residents seeking reelection may enter the endorsement process if they wish to be re-endorsed.

B. Speeches. Candidates are allowed to address the Assembly in a manner to be designated by the Speaker. The candidates shall be made aware of the format and timing of the address no fewer than 30 days prior to the meeting of the general Assembly.

C. Campaign. Refer to Section RFS Internal Operating Procedures V.D. for the Code for Campaigning applicable to the Trustee election.

D. Endorsement Process.
   1. Time. The endorsement of the resident and fellow candidates for council shall occur during the voting period at the Interim Assembly Meeting of the AMA-RFS. The Governing Council shall set the day and time. Candidates may also be endorsed during the Annual meeting by rules outlined below.

   2. Method of Endorsement. Where there is only one candidate for a given council, endorsement may be by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall be in order. Endorsements shall be by ballot. There shall be a separate ballot for each Council. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no ranking, and it should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed.

   3. Processing. No ballots will be cast after the expiration of the voting period. The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the boxes will be sequestered in a private location. At this time
the Chair of the Rules Committee will open the ballot box and the Rules Committee will then count the ballots and tabulate the results. Counting shall proceed by counting the number of affirmative votes for each candidate. Every candidate who receives an affirmative vote from greater than 50% of those who cast legal ballots shall be endorsed.

4. Late Endorsement. A candidate may ask for endorsement by the Assembly at the annual meeting of the Assembly. This is subject to the same rules described above and additionally requires a 2/3 vote of the Assembly for endorsement. In the case of an individual seeking late endorsement, any individual who has already been endorsed for the position shall be allotted equal time before the Assembly and shall have his or her materials reprinted in the Assembly handbook upon request.

E. Appeals. See RFS Internal Operating Procedures V.F.6.

F. Report to Assembly. The Resident or Fellow member of a council shall submit a written report of the Council’s activities to the Assembly biannually. This report will communicate Council Actions related to the concerns of the RFS.

3. AMA Young Physician Section. A guide to the AMA and the Young Physician Section. 2014. 27.

4. AMA Resident and Fellow Section. "Endorsement of Resident and Fellow Trustee." RFS Internal Operating Procedures. 2016:

V. Elections to Governing Council

A. Time of Election. The Chair-elect of the Governing Council shall be elected by the RFS Assembly at the Interim Meeting for a two-year term, which will include 6 months as Chair-elect, one full year as Chair, and 6 months as Immediate Past Chair. The six remaining Governing Council members shall be elected by the RFS Assembly at the Annual Meeting of the Section. The Governing Council shall set the day and hour of such elections and shall give the resident and fellow members of the AMA ample notification.

B. Nominations. Nominations for the Governing Council positions shall be received in advance of the Annual Meeting (Chair-elect Interim Meeting), pursuant to the rules of the RFS. The Presiding Officer shall allot time for further nominations to be made from the floor of the Business Meeting.

C. Eligibility.

1. All members of the RFS, including fourth year medical students who have matched into a residency program, shall be eligible for election to the Governing Council.

2. Any Governing Council member wishing to be a candidate for a position whose term overlaps with the one he or she is currently serving, must resign his or her current position. Such resignation should be announced prior to the submission deadline for the Governing Council position for which he or she wishes to be a candidate. An election to fill the announced vacancy shall occur at the next meeting of the Assembly; however, the vacancy shall not take effect until the conclusion of that meeting. Should there be no candidates for a given Governing Council position, resignation shall be allowed until the close of nominations on the floor of the Assembly.

3. Cessation of Eligibility. If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.11 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member ceases to meet the membership requirements of the RFS within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office until the completion of the Annual Meeting.

Relevant RFS & AMA Policy
Introduction
The topic of the report originated from Resolution 2: Facilitating Resident Transfers In and Out of Residency Programs, which was passed at the Resident and Fellow Section 2014 Annual Meeting. The 2014 resolution made the following argument in support of it’s resolve clauses:

“according to the National Resident Matching Program (NRMP), The Match represents a binding commitment between an applicant and a program, and a resident can transfer out of his/her residency program only for the following reasons and within these timeframes:

- “serious or extreme hardship” (no specified timeframe);
- Change of specialty (by January 15 prior to beginning training); and
- For any reason (only applies after 45 days of starting training);\(^{1,2,3}\)

The original resolution presented before the Assembly asked “that our AMA study: (1) the process by which residents transfer into and out of training programs and the frequency of these transfers; (2) the reasons residents wish to transfer and the relative frequency of these reasons; (3) the ability of these residents to find alternate positions; and (4) the effects of these transfers on both training programs and current residents in affected programs”\(^{3}\) and “that our AMA work with the NRMP to find a way to facilitate resident transfers in a way that is consistent, equitable, and is safe for patient care.”\(^{3}\)

However, while the reference committee heard testimony largely in support of the spirit of the resolution, testimony was also highlighted “the need to better define the problem before giving directives to create a solution.”\(^{4}\) As a result, the reference committee “felt that the scope of the study as initially proposed was too broad.”\(^{4}\) The Assembly agreed upon and passed the following language which is now RFS policy 296.001R:

296.001R Evaluating Resident Transfers in and Out of Residency Programs: That our AMA study the issue of resident transfers between programs to better identify the scope of this issue. (Resolution 2, A-14)

Discussion
Transferring residency programs is, by many accounts, a difficult and poorly characterized process. Motives and strategies for program transfers are not well defined and have not been studied. Data on the occurrence of this is seldom released.
According to the ACGME, approximately 1,500 residents transferred programs or specialties during the 2012-2013 year. This amount has remained fairly consistent over the past six years. While these transfer numbers are knowingly inaccurate due to the inclusion of those residents whose transfer was part of their original career path, such as moving from neurology to pediatric neurology, or from psychiatry to child psychiatry, the numbers provide some context to the issue. However, there is no objective data on the number of individuals who have attempted but failed to transfer residency programs.

Acquiring an exemption from the National Residency Match Program (NRMP) due to serious and extreme hardship or for change of specialty is possible; however, anecdotally, not easy. In fact, residents are not able to contact programs to even explore the possibility of transferring without said exemption. Doing so, would be a Match violation and may result in the resident being banned from the Match process or outright termination from their residency program.

Despite the lack of data, there are resources available to help residents and fellows transfer positions. The AMA currently posts vacant resident and fellow positions and there are other websites, such as residentswap.org and studentdoctor.net, and informal discussion boards that are also available.

**RECOMMENDATION**

Considering the current AMA resource available, we recommend:

1) That the AMA-RFS continue to actively promote the resident and fellow vacancy page.
2) That the AMA-RFS consider organizing the information on the resident and fellow vacancy page in a user-friendly format.
3) That the AMA-RFS initiate conversation to integrate the resident and fellow vacancies into FRIEDA, a resource well known to residents and fellows, to make the information more widely distributed and easily accessible.

**References**


**Relevant RFS & AMA Policy**
Introduction
Traditionally, post residency training fellowships have started immediately after the conclusion of residency, i.e. July 1. For the past fifteen years, orthopedic surgery has been unique by having nearly all of their fellowships start on August 1st. This practice is slowly expanding with Surgical Critical Care, Thoracic, Transplant, Colorectal and Pediatric Surgery Fellowships transitioning to the August 1st start date in 2016. Numerous other specialties are also transitioning to this. The benefits are thought to be related to alleviating some of the logistical challenges associated with completing residency on June 30th and beginning fellowship July 1.

Discussion
Often times, fellows are required to move to different cities or hospitals placing a significant challenge on them. Additionally, many of these fellowships may have orientation beginning before July 1 further complicating this issue. Additionally, it is thought that since many specialty board exams occur in the month of July, the lack of clinical obligations during that month will allow residency graduates to prepare for their exams.

Moving the fellowship start date also ensures that trained fellows are in the hospital during July, when new residents are just beginning their training and can be transitioned by their experienced fellows. However, resident health insurance, disability insurance, salary and malpractice benefits terminate at the conclusion of their residency leaving the potential for a gap month where the future fellow will be without benefits or salary.

This, in its own, places a unique set of challenges particularly complicated by provisions requiring individuals to maintain health insurance, be compliant with visa/immigration requirements or if a resident is actively involved in litigation.

Adoption of transitioning to the August 1st start date was generally supported by both residents and surgery program directors. Fellows, on the other hand, during a survey of the Council on Pediatric Subspecialties, had mixed preferences on the ideal start date of their fellowship (22%: July 1, 39%: July 15, 39%: August 1). Overall, programs felt that residents can purchase COBRA health insurance and that the gap in income was an acceptable tradeoff for the other perceived benefits.

Despite the complicated nature of this, no retrospective reviews have been performed to characterize the degree to which changing the fellowship start date alleviated or worsened the transition.
RECOMMENDATION
We would recommend that the AMA survey physicians who have undergone this revised fellowship start date to further evaluate the benefits and drawbacks from this transition.

References
1. Fellowship Start Date Action Team;

Relevant RFS & AMA Policy
Introduction
The topic of this report originated from a policy passed at the RFS 2015 Annual Meeting. The following is the language of RFS Policy 291.001R:

291.001R Improving Physician Well-Being by Exploring Partnerships with Companies that Promote Health and Fitness: That our AMA-RFS evaluate entering into arrangements with companies which promote health and fitness that are willing to provide discounts to AMA-RFS members. (Resolution 4, A-15)

The purpose of this report is to investigate the considerations of entering into business partnerships with health fitness companies. Health fitness companies is a broad term that includes fitness gyms, companies that encourage exercise, weight loss programs, and nutrition companies. This report is to advise the American Medical Association (AMA) of whether the benefits outweigh the risks, and if there is a gain for entering into partnerships with health fitness companies.

Discussion
Advantages
A discount to health and fitness companies would encourage resident and fellows to join the American Medical Association (AMA) for the discounts. This could potentially increase trainees’ participation and engagement in the AMA. Many of the current member discounts (such as insurance companies, car rental deals, etc.) do not appeal to most residents and fellows at this stage in their career and life. A fitness discount has universal appeal among residents and fellows of different ages and stages of life. This would also be in agreement with the current AMA initiatives to promote health and wellness amongst the residents and fellows section (RFS). Residents lead busy lifestyles that include working countless of hours. If the AMA had discounted fitness memberships, they could improve the physical health and wellbeing of its members as well as improve their participation in the AMA and further make strides in AMA projects such as health policies.

Disadvantages
The association of the AMA with one particular fitness brand may be seen unfavorably by some AMA constituents, as if the AMA favors one type of fitness or one company over the other. There is also concern that if a partner company makes poor decisions either through advertisements or politically, it will having a negative impacts on the AMA. Additionally, if a partner company was to change its practices or service offerings to its members after entering into agreement, and these changes are unfavorable to our members, then it will also negatively influence the AMA and its members. Lastly, many companies fit within the generic and broad spectrum identified in RFS policy 291.00R of “companies which promote health and fitness”; refining this definition and the scope of agreement will need to be considered before entering into partnerships.
Other Considerations
Other considerations include whether the partnering company available nationwide. If not, then only a portion of AMA members would receive those benefit and others will be left out and unable to fully take advantage of the member benefit. Another factor to consider is whether the deals AMA negotiated are better than other deals available, such as local university deals, or specials found via their advertisements. If they are equivalent or worse, then even if the AMA were partnered with these companies, the discounts would not be used because they are not truly benefitting our members. Lastly, further investigation into membership habits would need to be conducted to evaluate what percent of our members currently utilize AMA benefits. Also, when evaluating reasons to join the AMA, consider whether members report discount benefits as a reason to join.

While it may sound exciting to offer AMA membership discounts to individuals who are members of a fitness club, this may not change the overall appeal of engaging in fitness and wellness activities, or joining the AMA. There needs to be a strong incentive for residents and fellows to take part in their own fitness. The AMA should be a part of wellness initiatives and all aspects of physician’s health including proper exercise, diet and mental health. The AMA should explore partnerships with several companies and develop relationships with 2 to 3 companies within each category. Providing multiple options will most likely result in the greatest likelihood of benefiting AMA members as a whole. This strategy also avoids the pitfall of associating the AMA with any singular corporate company while giving the appearance of AMA health and fitness promotion as a whole.

Alternative Option
The committee discussed a possible alternative option due to the concern about developing a business partnership with one specific company. This option would promote current AMA initiatives of health and wellness, but avoid the disadvantages of entering into strict business partnerships and corporate ties. This option is to provide AMA membership discounts for any and all health fitness activities if a resident or fellow is able to provide proof that they have made steps to improve their health and wellness. For example, if a resident signs up for a fitness gym, the AMA would provide a refund or stipend that would be equivalent to giving them a percentage off of their membership dues. This concept could be expanded to other health and wellness areas, and would provide greater flexibility and more option to our members. This would also minimize the inherent risk of associating with entities whose missions and goals may not coincide with the AMA.

Offering discounted AMA membership dues to members who provide proof of a health or wellness promoting activity would be an alternative. This would provide a financial incentive for members to actively engage in their own health and wellness, and would allow members to choose an option that fits their needs (type of wellness, location, financial range, etc.) without the risks associated with aligning with a specific fitness/wellness company. Discounts could also be given for those interested in other health promoting activities, such as participating in a race.

Disadvantages to this approach include extra time and labor required by members and AMA staff to show proof of involvement and reimbursement processing. Additionally, residents may have free gym access at the hospital or institution where they are employed, so this benefit may not be of value for some AMA members and would need further study.
Case Example
We examined one case of a university’s collaboration with a fitness company. Here is what we found:

**Example:** Fitness gym partnership with University of California San Diego (UCSD) residency program

**Methodology:** Discussed the partnership with the gym manager.

**Gym:** 24 Hour Fitness

**Discount Details:**
- For all residents and health care workers at the UCSD medical campus. Monetary gym discounts can vary per gym membership. The discount extends to all other 24 hour Fitness Gyms.
- This discount was initiated by the gym and eventually extended to 3 other large medical centers in San Diego.
- No contract or official agreement was made between the gym and medical campuses.
- The manager stated that the discount increased membership from the medical campus, and that he did not know of any disadvantages for the gym.
- There was no official information in the resident contract or website discussing the gym membership discount.
- Official UCSD ID card was needed to initiate the discount.

**Conclusion**
In alignment with AMA national initiatives, it is reasonable to promote health and wellness among the resident and fellow constituents. Whether through a direct partnership with a company or a membership discount of the member’s choosing, these would all benefit the health and wellness of AMA members. However, there are many disadvantages and variable risks associated with partnering with one health company, and there are several membership questions and logistics regarding flexible reimbursement promotions that are still left unanswered and would need further study.

**RECOMMENDATION**
We strongly urge the AMA:
1) To promote health and wellness among its members.
2) To further investigate and explore partnerships to promote health and wellness among its members, including a partnership that provides some financial benefit to AMA members.
AMA-RFS RESOLUTIONS IN HOUSE OF DELEGATES
Memo to: AMA-RFS Assembly

From: Hans Arora, MD, PhD
AMA-RFS Chair

Date: June 2017

Subject: RFS HOD Items

RFS House of Delegates Items of Business relevant to the AMA-RFS:

Reference Committee A
- Resolution 101 – Eliminating Financial Barriers for Evidence-Based HIV Pre-Exposure Prophylaxis

Reference Committee B
- Resolution 201 – Improving Drug Affordability

Reference Committee C
- Resolution 301 – Mental Health Disclosures on Physician Licensing Applications

Reference Committee D
- Resolution 403 – Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking
- Resolution 404 – Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons
Whereas, Emtricitabine/tenofovir is an evidence-based component of HIV pre-exposure prophylaxis (PrEP); and

Whereas, PrEP reduces the risk of HIV infection among gay or bisexual men as well as transgender women by as much as 92% when used as prescribed; and

Whereas, In 2014, the Centers for Disease Control and Prevention issued guidelines stating that HIV PrEP should be considered for HIV-uninfected patients who are in an ongoing sexual relationship with an HIV-infected partner, are gay or bisexual men who have sex without a condom, or have a history of injection drug use; and

Whereas, Additional research indicates no new HIV infections with increasing use of HIV PrEP in a clinical practice setting; and

Whereas, There are reports of individuals being denied disability insurance due to concomitant HIV PrEP; and

Whereas, Insurance coverage for HIV PrEP often requires pre-authorization with no guarantee of insurance coverage; and

Whereas, Physicians commonly purchase disability insurance as means for long-term financial security; therefore be it

References:
RESOLVED, That our American Medical Association amend policy H-20.895 by addition to read as follows:

Pre-Exposure Prophylaxis for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA advocates that individuals not be denied various financial products, including disability insurance, on the basis of HIV pre-exposure prophylaxis (PrEP) use. (Modify Current HOD Policy)

Fiscal Note: not yet determined

Received: 02/20/17

RELEVANT AMA POLICY

Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases H-20.906
(1) Health Insurance
A currently held health insurance policy of a health care worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection.
(2) Disability Coverage
a) Each health care worker should consider the risks of exposure to infectious agents posed by his/her type of practice and the likely consequences of infection in terms of changes needed in that practice mode and select disability insurance coverage accordingly. The policy selected should contain a reasonable definition of "sickness" or "disability," an own-occupation clause, and guaranteed renewability, future insurability, and partial disability provisions;
b) In making determinations of disability, carriers should take into consideration the recommendations of the professional and institutional staff with whom an infected health care worker is associated, including the worker's own personal physician;
c) Since there are a variety of disability insurance coverages available and a diversity of practice modes, each health care professional should individually assess his/her risk of infection and that of his/her employees and select disability coverage accordingly. (CSA Rep. 4, A-03; Reaffirmed: CMS Rep, A-13)

Pre-Exposure Prophylaxis for HIV H-20.895
1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV, including use in women and minority populations, and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances (Res. 106, A-16; Modified: Res. 916, I-16)
WHEREAS, Recent media coverage of individual drugs such as sofosbuvir, epinephrine, naloxone and pyrimethamine has highlighted the skyrocketing cost of medications in the U.S., \(^1\) \(^2\) \(^3\) \(^4\) \(^5\); and

WHEREAS, These individual drug costs are not isolated phenomena but symbolic of a systemic crisis of drug affordability with devastating consequences for our patients and our health care system; \(^5\); and

WHEREAS, Prices for 1,200 existing generic drugs increased 450%, on average, in a single year (2013-2014); and

WHEREAS, Prices for 73 existing brand name drugs increased 75% or more since 2007; and

WHEREAS, The average price for oncology medications has doubled over the past decade, from $5,000 per month to $10,000 per month; and

WHEREAS, Of the 12 oncology drugs approved by the FDA in 2013, 11 were priced at more than $100,000 per year; and

WHEREAS, Spending on specialty drugs is expected to more than quadruple from $87 billion in 2012 to $400 billion in 2020, if nothing is done to address current and future prices; and

WHEREAS, AMA Policy Pharmaceutical Cost H-110.987 states, “Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers (PBMs) and health insurance companies”; and

WHEREAS, Drug pricing transparency is a necessary but not sufficient first step in addressing drug pricing affordability and increasing access to medicines; and

WHEREAS, Increasing drug affordability requires comprehensive legislation including transparency, notification and enforcement provisions including but not limited to price gouging provisions; therefore be it
RESOLVED, That our American Medical Association support drug price transparency legislation that requires pharmaceutical manufacturers to disclose, in a timely fashion, the basis for the prices of all prescription drugs, including but not limited to: (1) research and development costs paid by both the manufacturer and any other entity; (2) manufacturing costs; (3) advertising and marketing costs; (4) total revenues and direct and indirect sales; (5) unit price; (6) financial assistance provided for each drug including any discounts, rebates and/or prescription drug assistance; (7) any offshoring of either jobs or profits; (8) any reverse payment settlements; (9) payments to third parties—such as wholesalers, group purchasing organizations (GPOs), managed care organizations (MCOs), and pharmacy benefit management companies (PBMs) (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that requires pharmaceutical manufacturers to provide public notice before increasing the wholesale price of any brand or specialty drug by 10% or more each year or per course of treatment (New HOD Policy); and be it further

RESOLVED, That our AMA support legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients (New HOD Policy); and be it further

RESOLVED, That our AMA support the expedited review of generic drug applications and prioritize review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment. (New HOD Policy)

Fiscal Note: not yet determined

Received: 02/20/17

References:

RELEVANT AMA POLICY

Pharmaceutical Cost H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting. (CMS Rep. 2, I-15; Reaffirmed in lieu of Res. 817, I-16)

Cost of Prescription Drugs H-110.997
Our AMA:
(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients. (BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 530, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep. 3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11)

Reducing Prescription Drug Prices D-110.993
Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation. (CMS rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14)

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
Whereas, A 2007 study of state medical boards (SMB) in the *Journal of Medical Licensing and Discipline* found that 40% of physician license applications ask directly about mental illness, with 20% asking about impairment due to mental illness and 20% asking about diagnosis, treatment, admission to a treatment facility or a combination of these; and

Whereas, 37% of the SMBs that participated in the study stated that they have the ability to sanction physicians on the basis of information revealed about the presence of a psychiatric condition, rather than on the basis of impairment; and

Whereas, 37% of the SMBs that participated in the study also stated that they deal differently with physicians receiving psychiatric care versus medical care; and

Whereas, Often applications only require disclosure of physical health conditions only if it is likely to cause impairment; and

Whereas, Our AMA policy H-275.970 currently “encourages state licensing boards to require 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,” but does not specify whether or not the applicant is actively impaired; and

Whereas, AMA Ethical Opinion E-9.3.1 on professional rights and responsibilities states that a physician is impaired when physical or mental health “reaches the point of interfering with a physician’s ability to engage safely in professional activities”; and

Whereas, AMA Policy H-275.945 encourages the American Board of Medical Specialties and the Federation of State Medical Boards to provide the rationale behind inquiries on personal information, such as mental health; and

Whereas, Physicians may be less likely to seek treatment for mental health impairment for fear of sanctions or repercussions from regulatory bodies; therefore be it

RESOLVED, That our American Medical Association encourage state medical boards to consider physical and mental conditions similarly (New HOD Policy); and be it further

References:
RESOLVED, That our AMA encourage state medical boards to recognize that the presence of a mental health condition does not equate with an impaired ability to practice medicine (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy Licensure Confidentiality H-275.970 by addition and deletion to read as follow:

**Licensure Confidentiality H-275.970**
The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician's practice of medicine or 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); and be it further

RESOLVED, That our AMA encourage state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior. (New HOD Policy)

Fiscal Note: not yet determined

Received: 02/20/17

**RELEVANT AMA POLICY**

**Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973**
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place. (Res. 915, I-15; Revised: CME Rep. 01, I-16)

**Access to Mental Health Services H-345.981**
Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:
1. reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
2. improving public awareness of effective treatment for mental illness;
3. ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
4. tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person’s identity;
5. facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
Physician Health and Wellness E 9.3.1
To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. When health or wellness is compromised, so may the safety and effectiveness of the medical care provided. When failing physical or mental health reaches the point of interfering with a physician's ability to engage safely in professional activities, the physician is said to be impaired.

In addition to maintaining healthy lifestyle habits, every physician should have a personal physician whose objectivity is not compromised. Physicians whose health or wellness is compromised should take measures to mitigate the problem, seek appropriate help as necessary, and engage in an honest self-assessment of their ability to continue practicing.

Those physicians caring for colleagues should not disclose without the physician-patient's consent any aspects of their medical care, except as required by law, by ethical and professional obligation (Opinion E-9.031), or when essential to protect patients from harm. Under such circumstances, only the minimum amount of information required by law or to preserve patient safety should be disclosed.

The medical profession has an obligation to ensure that its members are able to provide safe and effective care. This obligation is discharged by:

- promoting health and wellness among physicians;
- supporting peers in identifying physicians in need of help;
- intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a physician health program;
- establishing physician health programs that provide a supportive environment to maintain and restore health and wellness;
- establishing mechanisms to assure that impaired physicians promptly cease practice;
- assisting recovered colleagues when they resume patient care;
- reporting impaired physicians who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations. This may entail reporting to the licensing authority. (I, II)

(Issued June 2004 based on the report “Physician Health and Wellness,” adopted December 2003.)

Self-Incriminating Questions on Applications for Licensure and Specialty Boards H-275.945
The AMA will: (1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information; (2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and (3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked. (BOT Rep. 1, I-933; CME Rep. 10 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)

Licensure Confidentiality H-275.970
The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require 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.
Infrequently, sixteen million Americans suffer from smoking-related disease, resulting in half a
million smoking-related deaths annually, including over 40,000 from secondhand smoke
exposure1 and the economic cost of smoking in the United States is over $300 billion a year2;
and
Whereas, Smoking is a notoriously difficult habit to quit, and over 90% of smokers who attempt
to quit fail3; and
Whereas, Harm reduction is a strategy to minimize harm to individuals and society from
hazardous behaviors that cannot be completely extinguished, such as clean needle exchange,
safe-sex education, or methadone maintenance therapy4,5,6; and
Whereas, The US Food and Drug Administration has concluded that there are no significant
safety risks associated with long-term nicotine-replacement therapy (NRT) or significant
potential for abuse or dependence7; and
Whereas, The Surgeon General’s 50-year report on smoking stated:
“the burden of death and disease from tobacco use in the United States is
overwhelmingly caused by cigarettes and other combusted tobacco products; rapid
elimination of their use will dramatically reduce this burden” (p. 871), and “the impact of
the noncombustible aerosolized forms of nicotine delivery on population health is much
more likely to be beneficial in an environment where the appeal, accessibility, promotion,
and use of cigarettes and other combusted tobacco products are being rapidly reduced”
(p. 589)7; and
Whereas, Several reviews and well controlled laboratory studies have shown that many
hazardous agents in cigarette smoke are not detectable in e-cigarette vapor or are only present
at much lower levels, typically significantly below one percent8,9,10 and do not warrant health
concerns when compared to occupational exposure limits11; therefore be it
RESOLVED, That our American Medical Association advocate for tobacco harm reduction
approaches to be added to existing tobacco treatment and control efforts (New HOD Policy);
and be it further
RESOLVED, That our AMA educate physicians and patients on the myriad health effects of
different nicotine products and emphasize the critical role of smoke and combustion in causing
disease (Directive to Take Action); and be it further
RESOLVED, That our AMA encourage physicians to adopt patient-specific, individualized approaches to smoking cessation, particularly for patients with disease secondary to smoking and for patients who have otherwise failed traditional methods for smoking cessation (New HOD Policy); and be it further

RESOLVED, That our AMA continue its focus on research to identify and expand options that may assist patients to transition away from smoking, including nicotine replacement therapies and noncombustible nicotine products (including e-cigarettes) (Directive to Take Action); and be it further

RESOLVED, That the AMA reaffirm its position on strong enforcement of US Food and Drug Administration and other agency regulations for the prevention of use of all electronic nicotine delivery systems and tobacco products by anyone under the legal minimum purchase age. This shall include marketing to children, direct use or purchasing by children and indirect diversion to children. Further, that our AMA reaffirm physician education of patients to limit these products for children in any and all capacity. (Reaffirm HOD Policy)

Fiscal Note: not yet determined

Received: 02/20/17

References:


RELEVANT AMA POLICY

Electronic Cigarettes, Vaping, and Health: 2014 Update H-495.972
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about “vaping” or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA encourages further clinical and epidemiological research on e-cigarettes. 3. Our AMA supports education of the public on electronic nicotine delivery systems (ENDS) including e-cigarettes. (CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Reaffirmed: Res. 421, A-15)

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986
H-495.986 Tobacco Product Sales and Distribution
Our AMA: (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors; (2) supports the development of n和社会 legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; (3) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors; (4) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (5) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (6) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (7) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Drugists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; (8) opposes the sale of tobacco at any facility where health services are provided; and (9) supports that the sale of tobacco products be restricted to tobacco specialty stores. (CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation I-09; Reaffirmation A-13; Reaffirmation A-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16)

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973
Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; and (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth. (Res. 206, I-13; Modified in lieu of Res. 511, A-14; Modified in lieu of Res. 518, A-14; Modified in lieu of Res. 519, A-14; Modified in lieu of Res. 521, A-14; Modified: CSAPH Rep. 2, I-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 412, A-15; Reaffirmed in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Reaffirmation A-16)
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404 (A-17)

Introduced by: Resident and Fellow Section

Subject: Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons

Referred to: Reference Committee D (, MD, Chair)

Whereas, The Hepatitis C virus (HCV) is estimated to be present in 17.4% of incarcerated individuals, accounting for approximately \( \frac{1}{3} \) of all US cases; and

Whereas, The Federal Bureau of Prisons currently recommends voluntary routine screening of HCV for all incarcerated persons without clear mandates for treatment; and

Whereas, Current guidelines by the American Association for the Study of Liver Diseases (AASLD) recommend treatment with regimens centered around the new direct acting antiviral medications in all cases of chronic Hepatitis C, due to an estimated cure rate greater than 90%; and

Whereas, A 2016 National Institutes of Health microsimulation estimated 5,500 to 12,700 new infections of HCV could be prevented over the next 30 years through routine prison screening and treatment; and

Whereas, Cost continues to be a limiting factor to the implementation of treatment; therefore be it

RESOLVED, That our American Medical Association support the implementation of routine screening for Hepatitis C virus (HCV) in prisons (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the initiation of treatment for HCV in all incarcerated patients with the disease and seeking treatment (New HOD Policy); and be it further

RESOLVED, That our AMA support negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications. (New HOD Policy)

References:
Fiscal Note: not yet determined

Received: 02/20/17

RELEVANT AMA POLICY

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing. (CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13)

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845

Our AMA will: (1) encourage the adoption of birth year-based screening practices for hepatitis C, in alignment with Centers for Disease Control and Prevention (CDC) recommendations; (2) encourage the CDC and state Departments of Public Health to develop and coordinate Hepatitis C Virus infection educational and prevention efforts; (3) support hepatitis C virus (HCV) prevention, screening, and treatment programs that are targeted toward maximum public health benefit; (4) support adequate funding by, and negotiation for affordable pricing for HCV antiviral treatments between the government, insurance companies and other third party payers, so that all Americans for whom HCV treatment would have a substantial proven benefit will be able to receive this treatment; and (5) recognize correctional physicians, and physicians in other public health settings, as key stakeholders in the development of HCV treatment guidelines. (Res. 906, I-12; Modified: Res. 511, A-15)
INFORMATIONAL REPORTS
Memo to: AMA-RFS Assembly

From: Hans Arora, MD, PhD
AMA-RFS Chair

Date: June 2017

Subject: Informational Reports to the RFS Assembly

The following reports are presented for the information of the RFS Assembly:

Delegate Report  RFS Caucus Actions
Report D  Sunset Mechanism Timing: Calendar v. Academic Year
Introduction

At the 2014 Resident and Fellow Section (RFS) Interim Meeting, Resolution 2 – Allowing the AMA-RFS Delegation to the HOD to Act as a Representative Body was adopted as follows:

RESOLVED, That the AMA-RFS Delegation to the AMA-HOD be allowed, after a 2/3 plus 1 majority vote of the Delegation (that can be called by any member of the delegation) to take vocal action on a resolution before the AMA-HOD that is outside the bounds of current AMA-RFS policy; and be it further

RESOLVED, That in such instances where the AMA-RFS Delegation takes action outside the bound of the AMA-RFS policy compendium such action will be reported to the AMA-RFS Assembly at its next meeting in the form of a report by the AMA-RFS Delegate that details the resolution in questions, the action taken, motivation for taking such action, and suggestions of specific AMA-RFS policy on the issue in question that the AMA-RFS Delegation believes should be adopted by the AMA-RFS Assembly.

At the 2015 RFS Annual Meeting, the RFS Assembly adopted Report B – AMA-RFS Caucus Structure and Function. This resulted in Section X. RFS Caucus of the AMA House of Delegates being added to the RFS Internal Operating Procedures (IOPs). This report is the result of Section X.C.1. Reporting of Caucus Actions, which states:

The RFS Delegate and Alternate shall be responsible for authorizing a report of actions taken, which shall be presented to the RFS Assembly at the next national meeting. This report will list the resolved clauses of all AMA HOD resolutions for which the RFS took a position, and will specifically identify those resolutions for which the RFS Caucus took a position that was not grounded in existing internal policy. It will also detail the action taken, motivation for taking such action, and suggestions for new AMA-RFS policy on the issue in question.

Accordingly, this report provides information pertaining to the actions of the RFS Caucus at the 2016 Interim Meeting of the AMA American Medical Association (AMA) House of Delegates (HOD) including suggestions for internal RFS policy. Appendix A contains the list of RFS Delegates and their endorsing societies.
Background
Resident representation in the AMA HOD began with the formation of the Resident and Fellows Section (RFS) of the AMA in 1974, which afforded residents and fellows a single delegate to represent their views and argue in favor of their resolutions in the HOD. It wasn’t until the Interim meeting of 2000, with the passage of AMA policy B-2.14, that the sectional delegate position was created, granting the RFS 1 delegate for each 2000 members, and drastically increasing resident and fellow representation in the HOD. During this same meeting, AMA Policy G-600.024 was passed, encouraging state delegations to set aside seats for resident members, which further increased the number of resident and fellows represented in the HOD.

As resident and fellow representation has increased, so has the level of organization of our delegates. In recent years, delegates have worked collaboratively, under the direction of the RFS Delegate and Alternate Delegate, who have granted them authority to speak “on behalf of the Resident and Fellows Section” in AMA reference committee hearings and in the HOD. Though our delegates have achieved a high degree of organization, our procedures for operating in the HOD have never been codified in the RFS IOPs or in AMA bylaw, and thus they have changed from year to year, sometimes progressing, and sometimes deteriorating due to lack of institutional memory.

As time has gone on, this persistently nebulous structure has led to numerous questions that have yet to be addressed by formal policy. Who exactly do resident and fellow sectional delegates represent? Who is part of the RFS “caucus”, and how should the caucus make decisions? What should the caucus do when faced with important resolutions for which we have no existing RFS policy? GC Report B from I-15 served to clarify this function as well as ratify exactly who comprised the RFS Caucus and how the caucus may explicitly act on items of business.

Within the system adopted by GC Report B, the RFS Caucus must adhere strictly to RFS internal policy when applicable, but may speak on important resolutions not touched on in internal policy with the approval of a 2/3 majority of an appropriately sized quorum of sectional delegates. In order to promote transparency in this process, recommendation C was included requiring that the the RFS Delegates report back to the assembly on AMA HOD items that the Caucus developed formal stances on. For items that the RFS Caucus developed stances where there was no prior RFS policy the report calls for providing rationale for this decision as well as suggestions internal RFS policy that the RFS assembly may consider adopting in the future.

Of note, prior to the drafting of this report, the RFS Caucus underwent a lengthy debate regarding its language, intent, and options. It was ultimately determined that two factors are of utmost importance to the RFS Caucus:

1. Transparency and the opportunity for RFS Assembly feedback on RFS Caucus actions
2. Quickly developing internal RFS policy on RFS Caucus vote items so these efforts are not duplicated in the future

In order to satisfy number 1, this report will be initially presented on the Virtual Reference Committee so all RFS Assembly members may provide thoughts and feedback on RFS Caucus actions. This may help inform the group regarding potential areas of improvement. In response
to number 2 the discussion was mixed with some members requesting formal recommendations within this report for assembly adoption and others raising interest in an affirmation calendar, similar to the sunset mechanism, where the RFS assembly may affirm or reject the actions of the RFS Caucus.

Numerous parties raised concern regarding a Governing Council report detailing policy recommendations on a breadth of topics that could potentially be extracted for individual debate on the RFS Assembly floor. This precedent has yet to be set with this report and it could serve to greatly derail the focus of the assembly. If the inclusion of direct policy recommendations in such a report is, in fact, the will of the House then a resolution with an IOP amendment to GC Report B language should be submitted so the RFS assembly may benefit from a thorough debate detailing the pros and cons of this motion. For now, the RFS Delegates have encouraged members of the RFS Caucus to identify RFS Caucus vote items of interest and author resolutions to submit to the RFS Assembly in order to fill these policy gaps. Furthermore, at I-16 the AMA-RFS assembly passed policy requiring the documentation of all AMA RFS Caucus members present for each caucus vote as well as their endorsing society. The goal of this is to improve transparency. During debate of this item, it was clear from the assembly floor that there is great trust placed in our AMA-RFS caucus given its direct election by the assembly.

For the purposes of this report, resolved clauses for resolutions are listed in full. Committee reports, however, will have titles and RFS policy only due to their lengths. Entire committee reports can be referenced via the AMA website. Caucus votes that were taken in order to interpret RFS policy for the purpose of determining strategy were not included in the section identifying caucus votes for items without prior RFS policy. Instead, these were included under the sections "Items the RFS Caucus Supported (or Opposed/Referred) Based on Internal RFS Policy".

Items The RFS Caucus Supported Based on Internal RFS Policy

Resolution 002: Living Organ Donation at the Time of Imminent Death
RESOLVED, That our American Medical Association study the implications of the removal of barriers to living organ donation at the time of imminent death.

AMA- RFS Policy or Comments:
370.997R Removing Barriers to Organ Donation
370.998R National Marrow Donor Program: Cord Blood Donation
370.999R National Marrow Donor Program

Resolution 003: Study of the Current Uses and Ethical Implications of Expanded Access Programs
RESOLVED, That our American Medical Association study the implementation of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies (Directive to Take Action); and be it further
RESOLVED, That our AMA study the ethics of expanded access programs, accelerated approval mechanisms, and payment reform models meant to increase access of experimental therapies.

AMA- RFS Policy or Comments:
470.000R Comprehensive Access to Safety Data from Clinical Trials
460.999R Alternative vs. Adjunctive Medical Treatments:

BOT Report 7: Supporting Autonomy for Patients with Differences of Sex Development

AMA- RFS Policy or Comments:
160.988R: Removing Barriers to Care for Transgender Patients
315.997R: Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients

CCB Report 1: Membership and Representation in the Organized Medical Staff Section - Updated Bylaws

AMA- RFS Policy or Comments: This allows for residents and fellows to be included in OMSS section/assembly. It is inherently in the best interest of the AMA RFS to support this regardless of previous policy.

CCB Report 2: Bylaw Amendments Pertaining to Late Resolutions and Emergency Business

AMA- RFS Policy or Comments: Practical procedural changes that would benefit the AMA RFS when it comes to late and emergency resolutions by clarifying this process.

BOT Report 2: AMA Support for State Medical Societies’ Efforts to Implement MICRA-Type Legislation

AMA- RFS Policy or Comments:
265.996R Defensive medicine
335.999R Medical errors and physician standards
435.997R Opposition of Central Data Collections of Physicians (in Particular Residents) Named in Malpractice Suits

BOT Report 3: Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing

AMA- RFS Policy or Comments:
100.991R Use of a Single National Prescription Drug Monitoring Program (PDMP)
Resolution 201: Removing Restrictions on Federal Funding for Firearm Violence Research
RESOLVED, That our American Medical Association provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions. (Directive to Take Action)

AMA- RFS Policy or Comments:
145.998R Restoring CDC Funding to Research Gun Violence
145.999R AMA Campaign to Reduce Firearm Deaths

Resolution 202: Inclusion of Sexual Orientation and Gender Identity Information in Electronic Health Records
RESOLVED, That our American Medical Association advocate for inclusion of sexual orientation and gender in electronic health records (EHRs). (New HOD Policy)

AMA- RFS Policy or Comments: This was an AMA RFS authored resolution.

Resolution 206: Advocacy and Studies on Affordable Care Act Section 1332 (State Innovation Waivers)
RESOLVED, That our American Medical Association advocate that the “deficit-neutrality” component of the current HHS rule for Section 1332 waiver qualification be considered only on long-term, aggregate cost savings of states’ innovations as opposed to having costs during any particular year, including in initial “investment” years of a program, reduce the ultimate likelihood of waiver approval (New HOD Policy); and be it further
RESOLVED, That our AMA study reforms that can be introduced under Section 1332 of the Affordable Care Act in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of patients, healthcare providers and states, and encourages state societies to do the same. (Directive to Take Action)

AMA- RFS Policy or Comments:
165.992R President Barack Obama’s Health Care Plan
165.996R The Fundamental Importance of Universal Access

Resolution 212: Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation
RESOLVED, That our American Medical Association support the inclusion of a patient’s biological sex, gender identity, sexual orientation, preferred gender pronoun(s), and (if applicable) surrogate identifications in medical documentation and related forms in a culturally-sensitive and voluntary manner (New HOD Policy); and be it further
RESOLVED, That our AMA advocate for collection of patient data that is inclusive of sexual orientation/gender identity for the purposes of research into patient health. (New HOD Policy)

AMA- RFS Policy or Comments:
Resolution 214: Firearm Related Injury and Death: Adopt a Call to Action
RESOLVED, That our American Medical Association endorse the specific recommendations
made by an interdisciplinary, inter-professional group of leaders from the American
Academy of Family Physicians, American Academy of Pediatrics, American College of
Emergency Physicians, American Congress of Obstetricians and Gynecologists, American
College of Physicians, American College of Surgeons, American Psychiatric Association,
American Public Health Association, and the American Bar Association in the publication
“Firearm-Related Injury and Death in the United States: A Call to Action From 8 Health
Professional Organizations and the American Bar Association,”*** which is aimed at
reducing the health and public health consequences of firearms and lobby for their adoption.
(Directive to Take Action)\textsuperscript{additional:}

RESOLVED that our American Medical Association actively advocate for the following public
health approach to reducing gun violence:
1. Support universal background checks for all gun purchases or transfers of ownership
2. Oppose laws that forbid physician discussions of gun ownership
3. Oppose laws that restrict documentation of gun ownership conversations in the medical
record
4. Support adequate resources to facilitate coordination among physicians and state, local,
and community-based behavioral health systems so they can provide care to patients, raise
awareness, and reduce social stigma of mental and substance use disorders
5. Support reporting laws that protect patient confidentiality and do not deter patients from
seeking treatment of a mental or substance use disorder.
6. Support reporting laws that limit gun access to individuals who may harm themselves or
others, but do not limit access solely on the basis of a mental or substance use disorder
7. Support establishment of fair, equitable, and reasonable processes for restoration of gun
access after it has been limited
8. Support restrictions for civilian use on the manufacture and sale of large-capacity
magazines and firearms with features designed to increase their rapid and extended killing
capacity
9. Support adequate funding to the Centers for Disease Control and Prevention, National
Institutes of Health, and National Institute of Justice for the study of the effect of gun
violence and unintentional gun-related injury on public health and safety.
10. Oppose restrictions on access to data related to gun violence and unintentional gun-
related injury

AMA- RFS Policy or Comments:
145.998R Restoring CDC Funding to Research Gun Violence
145.999R AMA Campaign to Reduce Firearm Deaths

Resolution 218: Support for Prescription Drug Monitoring Programs
RESOLVED, That our American Medical Association continue to encourage Congress to
assure that the National All Schedules Prescription Electronic Reporting Act (NASPER)
and/or similar programs be fully funded to allow state prescription drug monitoring programs
(PDMPs) to remain viable and active (New HOD Policy); and be it further
RESOLVED, That our AMA work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices. (Directive to Take Action)

AMA- RFS Policy or Comments:
100.991R Use of a Single National Prescription Drug Monitoring Program (PDMP)

Resolution 221: Electronic Medical Records Recovery Fee
RESOLVED, That our American Medical Association work to create legislation to be introduced to the US Congress that would eliminate the costs to physicians associated with recovering patient health care records from a previous electronic medical records (EMR) vendor, when they upgrade to a new EMR vendor. (Directive to Take Action)

AMA- RFS Policy or Comments:
100.991R Use of a Single National Prescription Drug Monitoring Program (PDMP)

Resolution 222: Prohibition of Clinical Data Blocking
RESOLVED, That our American Medical Association advocate for the adoption of federal and state legislation and regulations to prohibit health care organizations and networks from blocking the electronic availability of clinical data to non-affiliated physicians who participate in the care of shared patients, thereby interfering with the provision of optimal, safe and timely care (New HOD Policy); and be it further
RESOLVED, That our AMA advocate for the adoption of federal and state legislation and regulations to place strict limits on the fees imposed by electronic health record vendors for the implementation and ongoing use of data sharing interfaces. (New HOD Policy)

AMA- RFS Policy or Comments:
480.998R Interoperability of Medical Devices

Resolution 301: Expanding the Treatment of Opioid Dependence Using Medication-Assisted Treatment by Physicians in Residency Training Programs
RESOLVED, That our American Medical Association encourage the expansion of residency and fellowship training opportunities to provide clinical experience in the medication-assisted treatment of opioid use disorders, under the supervision of an appropriately trained physician (New HOD Policy); and be it further
RESOLVED, That our AMA support additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the medication-assisted treatment of opioid use disorders. (New HOD Policy)

AMA- RFS Policy or Comments: This is an AMA-RFS authored resolution.

Resolution 302: Protecting the Rights of Breastfeeding Residents and Fellows
RESOLVED, That our American Medical Association work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME), to mandate language in housestaff manuals or similar policy references of all training programs on the protected
time and locations for milk expression and storage of breast milk (Directive to Take Action); and be it further

RESOLVED, That our AMA work with appropriate bodies, such as the ACGME and the Association of American Medical Colleges, to include language related to the learning and work environments for breast feeding mothers in regular program reviews. (Directive to Take Action)

AMA- RFS Policy or Comments:
This is an AMA-RFS authored resolution.

Resolution 303: Primary Care and Mental Health Training in Residency
RESOLVED, That our American Medical Association advocate for the incorporation of integrated mental health and primary care services into existing psychiatry and primary care training programs’ clinical settings (New HOD Policy); and be it further

RESOLVED, That our AMA encourage primary care and psychiatry residency training programs to create and expand opportunities for residents to obtain clinical experience working in an integrated mental health and primary care model, such as the collaborative care model (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings. (New HOD Policy)

AMA- RFS Policy or Comments: This is an AMA-RFS authored resolution.

Resolution 304: Improving Access to Care and Health Outcomes
RESOLVED, That our American Medical Association support training opportunities for students and residents to learn cultural competency from community health workers.

AMA- RFS Policy or Comments: This is an AMA-RFS authored resolution.

Resolution 305: Privacy, Personal Use and Funding of Mobile Devices
RESOLVED, That our American Medical Association encourage further research in integrating mobile devices in clinical care, particularly to address challenges of reducing work burden while maintain clinical autonomy for residents and fellows (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with the Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure a more uniform regulation of mobile devices in medical education and clinical training (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines in using personal devices in clinical environment.
Resolution 312: Eliminating the Tax Liability for Payment of Student Loans
RESOLVED, That our American Medical Association work with the Internal Revenue Service to eliminate the tax liability when private employers provide the funds to repay student loans for physicians who agree to work in an underserved area.

AMA- RFS Policy or Comments:
200.999R Addressing the Physician Workforce Shortage by Increasing GME Funding;
305.980R Loan Repayment for Physicians in Designated Shortage Areas;
405.988R Loan Payback in Shortage Areas

CME Report 1: Access to Confidential Health Services for Medical Students and Physicians

AMA- RFS Policy or Comments:
310.514R Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance
275.999R Psychotherapy for Medical Students and Residents

CLRPD Report 1: Renew delineated section status for the MAS and the IPPS through 2021

AMA- RFS Policy or Comments: This provides additional venues for RFS members to get involved in the AMA and therefore is inherently in the best interest of the section.

CMS Report 6: Integration of Mobile Health Applications and Devices into Practice

AMA- RFS Policy or Comments:
RFS Policy 481.000R Familiarity and Utilization of Mobile Medical Technology (A-14)

Resolution 802: Eliminate "Fail First" Policy in Addiction Treatment
RESOLVED, That our American Medical Association advocate for the elimination of the “fail first” policy implemented by insurance companies for addiction treatment. (New HOD Policy)

AMA- RFS Policy or Comments:
95.999R

Resolution 803: Reducing Perioperative Opioid Consumption
RESOLVED, That our American Medical Association encourage hospitals to adopt practices for the management of perioperative pain that include services dedicated to acute pain management and the use of multimodal analgesia strategies aimed at minimizing opioid administration without compromising adequate pain control during the perioperative period. (New HOD Policy)

AMA- RFS Policy or Comments: This was an AMA-RFS authored resolution
Resolution 902: Removing Restrictions on Federal Public Health Crisis Research
RESOLVED, That our American Medical Association recognize the importance of timely research and open discourse in combatting public health crises (New HOD Policy); and be it further

RESOLVED, That our AMA oppose efforts to restrict funding or suppress the findings of biomedical and public health research for the purpose of influencing political discourse. (Directive to Take Action)

AMA- RFS Policy or Comments:
145.00R

Resolution 904: Improving Mental Health at Colleges and Universities for Undergraduates
RESOLVED, That our American Medical Association support accessibility and de-stigmatization as strategies in mental health measures implemented by colleges and universities, in order to improve the provision of care and increase its use by those in need (New HOD Policy); and be it further

RESOLVED, That our AMA support colleges and universities in publicizing the importance of mental health resources, with an emphasis on the availability and efficacy of such resources (New HOD Policy); and be it further

RESOLVED, That our AMA support collaborations of university mental health specialists and local health centers in order to provide a larger pool of resources, such that any student be able to access care in a timely and affordable manner. (New HOD Policy)

AMA- RFS Policy or Comments:
165.995R -AMA-Health Care Delivery Task Force,
310.514R - Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance:

Resolution 905: Chronic Traumatic Encephalopathy (CTE) Awareness
RESOLVED, That our American Medical Association amend part one of Policy H-470.954 by addition and deletion to read as follows:
Reduction of Sports-Related Injury and Concussion
1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.; and (c) promote education for physicians and the public on the detection, treatment and prognosis of chronic traumatic encephalopathy (CTE). (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA work with interested agencies and organizations to advocate for further research into the cause.

AMA- RFS Policy or Comments:
This was an AMA RFS authored resolution

Resolution 906: Universal Color Scheme for Respiratory Inhalers
RESOLVED, That our American Medical Association work with leading respiratory inhaler manufacturing companies and health agencies such as the Federal Drug Administration and the American Pharmacists Association to develop consensus of a universal color scheme for short-acting beta-2 agonist respiratory inhalers that are used as “rescue inhalers” in the United States (Directive to Take Action); and be it further

RESOLVED, That our AMA work with leading respiratory inhaler manufacturing companies to ensure the universal color scheme for respiratory inhalers would allow for the least disruption possible to current inhaler colors, taking into account distribution of each brand and impact on current users if color were to change (Directive to Take Action); and be it further

RESOLVED, That our AMA work with leading respiratory inhaler manufacturing companies to ensure that universal color scheme for respiratory inhalers be designed for adherence and sustainability, including governance for future companies entering the respiratory inhaler market, and reserving colors for possible new drug classes in the future. (Directive to Take Action)

AMA- RFS Policy or Comments: This was an AMA RFS authored resolution.

Resolution 907: Clinical Implications and Policy Considerations of Cannabis Use
RESOLVED, That our American Medical Association amend Policy H-95.998 by deletion to read as follows:

H-95.998, AMA Policy Statement on Cannabis
Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) sale of cannabis should not be legalized; (3) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use; and (4) additional research should be encouraged. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend Policy D-95.976 by deletion to read as follows:

D-95.976, Cannabis - Expanded AMA Advocacy
1. Our AMA will educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH Report 2, I-13, A Contemporary View of National Drug Control Policy, and CSAPH Report 3, I-09, Use of Cannabis for Medicinal Purposes, and as additional scientific evidence becomes available.
2. Our AMA urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research.
3. Our AMA will also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a “public health”, as contrasted with a “criminal,” approach to cannabis.
4. Our AMA shall encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States."

AMA- RFS Policy or Comments: This was an AMA RFS authored resolution.

Resolution 909: Promoting Retrospective and Cohort Studies on Pregnant Women and Their Children
RESOLVED, That our American Medical Association recommend to the US Department of Health and Human Services that the Federal Policy for the Protection of Human Subjects, or “Common Rule”, be updated to define pregnant women as “scientifically complex” rather than a “vulnerable population” for research purpose (Directive to Take Action); and be it further

RESOLVED, That our AMA urge the federal government to prioritize clinical research and generation and dissemination of data, emphasizing retrospective and cohort studies, on common medications’ effects on underlying medical conditions across the entire continuum from pregnancy through lactation and development to better inform prescribing (New HOD Policy); and be it further

RESOLVED, That our AMA support federal legislation to 1) establish an interagency taskforce within the Department of Health and Human Services to improve federal interagency and key stakeholder communication, coordination and collaboration to advance research on medications in pregnancy and breastfeeding, and 2) to require the United States Food and Drug Administration to provide regular reports to Congress tracking the inclusion of pregnant and breastfeeding women in clinical trials. (New HOD Policy)

AMA- RFS Policy or Comments:
310.896R Support for Women's Health
420.998R Guidelines on the Protection of Pregnant Health Care Workers and Their Fetuses From Exposure to Potential Infectious/Teratogenic Agents

Resolution 910: Disparities in Public Education as a Crisis in Public Health and Civil Rights
RESOLVED That our American Medical Association consider continued educational disparities based on ethnicity, race and economic status a detriment to the health of the nation (New HOD Policy); and be it further

RESOLVED That our AMA issue a call to action to all educational private and public stakeholders to come together to organize and examine, and using any and all available scientific evidence, to propose strategies, regulation and/or legislation to further the access of all children to a quality public education as one of the great unmet health and civil rights challenges of the 21st century. (Directive to Take Action)

AMA- RFS Policy or Comments:
The AMA RFS has policy opposing health disparities and supporting minority groups.
Resolution 913: Improving Genetic Testing and Counseling Services in Hospitals and Healthcare Systems

RESOLVED, That our American Medical Association support efforts to assess the usage of genetic testing and need for counseling services, physician preparedness in counseling patients or referring them to board-certified genetics specialists (New HOD Policy); and be it further

RESOLVED, That our AMA encourage efforts to create and disseminate guidelines for best practice standards concerning counseling for genetic test results (New HOD Policy); and be it further

RESOLVED, That our AMA support further research into and open discourse concerning issues in medical genetics, including the genetic specialist workforce shortage, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic test results and counseling on patient satisfaction. (New HOD Policy)

AMA- RFS Policy or Comments: 480.999R

Resolution 916: Women and Pre-Exposure Prophylaxis (PrEP)

RESOLVED, Our American Medical Association partner with the appropriate organizations to increase community awareness about Pre-exposure prophylaxis (PrEP) by developing a women-focused PrEP education and social marketing campaign aimed at reaching PrEP eligible women in the U.S., particularly women of color (Directive to Take Action); and be it further

RESOLVED, Our AMA make readily available the current guidelines on Pre-exposure prophylaxis (PrEP) to increase knowledge and skills among family planning and other sexual and reproductive health care providers, particularly in areas with high HIV incidence (Directive to Take Action); and be it further

RESOLVED, Our AMA encourage residency programs (e.g., Obstetrics and Gynecology, Family Medicine) to train future physicians to offer and administer HIV prevention services, including Pre-exposure prophylaxis (PrEP), and improve providers’ ability to respond holistically to women living with and vulnerable to HIV (New HOD Policy); and be it further

RESOLVED, That our AMA encourage relevant organizations to develop training for physicians on HIV prevention services, including Pre-exposure prophylaxis (PrEP) (New HOD Policy); and be it further

RESOLVED, That our AMA encourage family planning, sexual health, and primary care providers to facilitate the integration of Pre-exposure prophylaxis (PrEP) services within clinics that serve HIV-vulnerable women and communities highly impacted by HIV. (Reaffirm HOD Policy)

AMA- RFS Policy or Comments:
Resolution 919: Coal-Tar Based Sealcoat Threat to Human Health and the Environment
RESOLVED, That our American Medical Association advocate for national legislation to ban the use of pavement sealcoats that contain polycyclic aromatic hydrocarbons (PAH); or at least, use sealcoat products that contain low or no PAH, specifically products where the concentration of PAH is less than 1/1000th the concentration in coal-tar sealcoats. (Directive to Take Action)

AMA- RFS Policy or Comments:
441.969R Environmental Toxins and Reproductive Health

Resolution 922: Responsible Parenting and Access to Family Planning
RESOLVED, That our American Medical Association reaffirm its commitment to work with all of the national medical societies and other interested organizations involved in women’s health care to ensure the education of women on the proper use of Food and Drug Administration- approved methods of family planning and assure that reproductive counseling is accessible and appropriately funded. (Reaffirm HOD Policy)

AMA- RFS Policy or Comments:
420.995R Teenage Pregnancy Prevention

Resolution 925: Graphic Warning Label on all Cigarette Packages
RESOLVED, That our American Medical Association evaluate all opportunities for effective advocacy by organized medicine to require graphic warning labels depicting the dangers of smoking on all cigarette packages (Directive to Take Action); and be it further

RESOLVED, That our AMA endorse efforts of the Campaign for Tobacco Free Kids and the Food and Drug Administration to require tobacco companies to include graphic warning labels depicting the dangers of smoking on all cigarette packages. (Directive to Take Action)

AMA- RFS Policy or Comments:
490.999R
505.994R

Resolution 927: The DEA Order to Reduce Opioid Production
RESOLVED, That our American Medical Association encourage relevant stakeholders to research the overall effects of opioid production cuts (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the DEA to postpone any opioid production cuts until the potential effects of production quotas are better elucidated (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the DEA to be more transparent when developing medication production guidelines. (New HOD Policy)
AMA- RFS Policy or Comments: This was an AMA RFS authored resolution.

CSAPH Report 4: Hormone Therapies: Off-Label Uses and Unapproved Formulations

AMA- RFS Policy or Comments:
440.970R Direct to Consumer Advertising

Items The RFS Caucus Opposed or Supported Referral Based on Internal RFS Policy:

None for I-16.

Items Requiring RFS Caucus Vote:

Late Resolution 223: Emergency Post Election Support for Principles of the Patient Protection and Affordable Care Act

RESOLVED, That our American Medical Association make a public statement that any health care reform legislation considered by Congress ensure continued improvement in patient access to care and patient health insurance coverage by maintaining:

1) Guaranteed insurability, including those with pre-existing conditions, without medical underwriting,

2) Income-dependent tax credits to subsidize private health insurance for eligible patients,

3) Federal funding for the expansion of Medicaid to 138% of the federal poverty level in states willing to accept expansion, as per current AMA policy (D-290.979),

4) Maintaining dependents on family insurance plans until the age of 26,

5) Coverage for preventive health services,

6) Medical loss ratios set at no less than 85% to protect patients from excessive insurance costs. (Directive to Take Action)

Rationale: The AMA RFS Caucus is very concerned about the future of healthcare in America, especially if patients lose healthcare due to the repeal of the Affordable Care Act. We worked with a large number of other groups within the AMA HOD in order to craft this language for tenants that we feel our assembly would support in order to send a message that our AMA works hard to protect our patients

Caucus Vote: **Support**
Outcome: **Substitute Language, passed**

RFS Caucus Attendance: Michael Lubrano, MD; Ben Karfunkle MD; John Corker, MD; William Doetsch, MD; Simon Faynboym, MD; Sean Figy, MD; Laura Gephart, MD; Stephanie Howe Guarino, MD; Shady Henien, MD; Aaron Kithcart, MD, PhD; Steve Lee, MD; Casey Melcher, MD; Luke Selby, MD; Christopher Worsham, MD; Tyler Andre, MD; McKinley Glover, MD; Jason Hall, MD, JD; Michael Knight, MD; Sean Moran, MD; Daniel O’Brien; Klint Peebles, MD; Robert Viviano, MD; Jordan Warchol, MD; Monica Wood, MD; Ariel Anderson, MD; Laura Halpin, MD, PhD; Samuel Mathis, MD; Matthew McNelley, MD  (Note: Composition may have changed prior to caucus votes as attendance was taken at start of RFS Caucus meeting. Quorum was achieved for each vote.)

Resolution 602: Equality and Resolution
Resolution 604: Oppose Physician Gun Gag Rule Policy by Taking our AMA Business Elsewhere

(602): RESOLVED, That all future meetings and conferences organized and/or sponsored by our American Medical Association, not yet contracted, only be held in towns, cities, counties, and states that do not have discriminatory policies based on race, color, religion, ethnic origin, national origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age.

(604): RESOLVED, AMA adopt policy that bars our AMA from holding HOD meetings in states with physician gun gag rule laws, AMA contact governors and convention bureaus of states that have enacted physician gun gag rules and inform them that our AMA will no longer hold HOD meetings in their state, until the restrictive physician gun gag rule is repealed or struck down by the courts.

Rationale: The AMA RFS Caucus feels strongly about this issue and there was a healthy debate about the pros and cons of removing our business from states with discriminatory legislation or legislation that impaired physicians from assessing their patient’s risk for adverse health events/outcomes. We are concerned that removing our business from individual states could impair our ability to work with that state, particularly that states medical association, in order to improve the disparities that negative legislation imparts on their population. Given the complex nature of this issue we recommended referral to study.

Caucus Vote: Refer for Study
Outcome: Referred to Study

RFS Caucus Attendance: Michael Lubrano, MD; Ben Karfunkle, MD; Naiim Ali, MD; William Doetsch, MD; Sean Figy, MD; Laura Gephart, MD; Shady Henien, MD; Aaron Kithcart, MD, PhD; Steve Lee, MD; Casey Melcher, MD; Claire Murphy, MD; Vanessa Stan, MD; Christopher Worsham, MD; McKinley Glover, MD; Matthew Lecuyer, MD; Sean Moran, MD; Klint Peebles, MD; Robert Viviano, MD; Jordan Warchol, MD; Laura Halpin, MD, PhD; (Note: Composition may have changed prior to caucus votes as attendance was taken at start of RFS Caucus meeting. Quorum was achieved for each vote.)

Resolution 912: Needle / Syringe Disposal

RESOLVED, That our American Medical Association support the requirement that medical facility needle/syringe disposal devices be as theft-proof and tamper-proof as possible; this requirement could be established by rule or by statute (New HOD Policy); and be it further

RESOLVED, That our AMA support the requirement that stored used needles/syringes be properly secured so as to discourage theft (New HOD Policy); and be it further

RESOLVED, That our AMA support the requirement that theft and tamper-proof containers be placed in public restrooms for the purpose of needle/syringe disposal; an ideal device would crush the syringe as part of the disposal process; (New HOD Policy) and be it further

RESOLVED, That our AMA encourage those communities with a IV drug abuse population to establish a needle exchange program, since this helps eliminate the demand for used needles/syringes. (New HOD Policy)
Rationale: This is an important topic given the opioid epidemic and the public health data regarding the utility of needle sharing programs is strong. This resolution aimed to improve AMA policy in this area.

Caucus Vote: **Support**
Outcome: **Adopted with friendly amendments**

RFS Caucus Attendance: Michael Lubrano, MD; Ben Karfunkle MD; John Corker, MD; William Doetsch, MD; Simon Faynboym, MD; Sean Figy, MD; Laura Gephart, MD; Stephanie Howe Guarino, MD; Shady Henien, MD; Aaron Kithcart, MD, PhD; Steve Lee, MD; Casey Melcher, MD; Luke Selby, MD; Christopher Worsham, MD; Tyler Andre, MD; McKinley Glover, MD; McKinley Glover, MD; Jason Hall, MD, JD; Michael Knight, MD; Sean Moran, MD; Daniel O'Brien; Klint Peebles, MD; Robert Viviano, MD; Jordan Warchol, MD; Monica Wood, MD; Ariel Anderson, MD; Laura Halpin, MD, PhD; Samuel Mathis, MD; Matthew McNelley, MD (Note: Composition may have changed prior to caucus votes as attendance was taken at start of RFS Caucus meeting. Quorum was achieved for each vote.)

**Resolution 915: Women and Alzheimer's Disease**

RESOLVED, That our American Medical Association participate in efforts to raise awareness of the noted sex and gender differences in incidence and etiology of Alzheimer’s disease and related dementias (Directive to Take Action); and be it further

RESOLVED, That our AMA make readily available to physicians the relevant guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage physicians to consider performing regular cognitive testing as a part of wellness visit protocols for older adults, especially patients with increased risk of developing Alzheimer's disease and other forms of dementia, including, but not limited to, female sex, genetics, and cardiovascular co-morbidities (New HOD Policy); and be it further

RESOLVED, That our AMA encourage increased enrollment in clinical trials with all appropriate patients with Alzheimer’s and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's and related dementia. (New HOD Policy)

Rationale: As the elderly population continues to grow in numbers, this is going to become more and more relevant for many of our specialties. Research into gender differences in Alzheimer's could potentially aid in developing specific targeted treatments for the disorder, and it is relevant to pursue this line of research.

Caucus Vote: **Support**
Outcome: **Adopted as Amended**

RFS Caucus Attendance: Michael Lubrano, MD; Ben Karfunkle, MD; Hans Arora, MD; Shady Henien, MD; Steve Lee, MD; Casey Melcher, MD; Vanessa Stan, MD; Christopher Worsham, MD; Tyler Andre, MD; Michael Knight, MD; Matthew Lecuyer, MD; Sean Moran, MD; Klint Peebles, MD; Robert Viviano, MD; Ariel Anderson, MD; Laura Halpin, MD, PhD; Samuel Mathis, MD; Matthew McNelley, MD; Ryan Ribeira, MD (Note: Composition may have changed prior to caucus votes as attendance was taken at start of RFS Caucus meeting. Quorum was achieved for each vote.)
Resolution 917: Youth Incarceration in Adult Prisons

RESOLVED, That our AMA work with appropriate organizations to address age cutoffs for children (individuals less than 18 years of age) in adult prisons (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for elimination of the incarceration of children (individuals less than 18 years of age) in adult prisons for non-violent crimes (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the passage of legislation that addresses reform for children (individuals less than 18 years of age) in adult prisons with respect to developing appropriate guidelines for parole, expungement and sealing of records, and solitary confinement (Directive to Take Action); and be it further

RESOLVED, That our AMA support early intervention and rehabilitation for children (individuals 18 years of age or younger) that have been incarcerated in adult prisons. (New HOD Policy)

Rationale: The AMA RFS caucus is very sensitive to public health issues that particularly affect those populations among us whom are most vulnerable. Children fall into this category. Youth incarceration is a unique and important issue that affects the health and well being of many children in this country and the AMA RFS Caucus felt it was important to support this issue.

Caucus Vote: Support
Outcome: Adoption of Substitute Resolution
RFS Caucus Attendance: Michael Lubrano, MD; Ben Karfunkle, MD; Hans Arora, MD; Shady Henien, MD; Steve Lee, MD; Casey Melcher, MD; Vanessa Stan, MD; Christopher Worsham, MD; Tyler Andre, MD; Michael Knight, MD; Matthew Lecuyer, MD; Sean Moran, MD; Klint Peebles, MD; Robert Viviano, MD; Ariel Anderson, MD; Laura Halpin, MD, PhD; Matthew McNelley, MD; Ryan Ribeira, MD (Note: Composition may have changed prior to caucus votes as attendance was taken at start of RFS Caucus meeting. Quorum was achieved for each vote.)

Emergency Resolution 1001: Support for DACA-eligible healthcare professionals

RESOLVED, That our AMA issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

Rationale: The AMA RFS Caucus felt strongly that it is our duty to support and protect trainees who are DACA-eligible healthcare professionals. There are medical students and residents across the U.S. who fall into this category. Given current concerns regarding the deportation of undocumented immigrants, this issue was not only relevant but highly time sensitive. Our goal was to have the AMA adopt policy with a direct call to action in order to support this group of professionals.

Caucus Vote: Support and Co-Sponsor
Outcome: Adopted
RFS Caucus Attendance: Michael Lubrano, MD; Ben Karfunkle, MD; Naiim Ali, MD; William Doetsch, MD; Sean Figy, MD; Laura Gephart, MD; Shady Henien, MD; Aaron Kithcart, MD,
PhD; Steve Lee, MD; Casey Melcher, MD; Claire Murphy, MD; Vanessa Stan, MD; Christopher Worsham, MD; McKinley Glover, MD; Matthew Lecuyer, MD; Sean Moran, MD; Klint Peebles, MD; Robert Viviano, MD; Jordan Warchol, MD; Laura Halpin, MD, PhD; (Note: Composition may have changed prior to caucus votes as attendance was taken at start of RFS Caucus meeting. Quorum was achieved for each vote.)

Discussion
RFS sectional delegates are elected by the RFS assembly to represent the interests of residents and fellows. As resident and fellow representation has grown, and the pace of healthcare policy change in the US has increased, the RFS Caucus has increasingly found itself in situations where the HOD is debating a question of great importance and relevance to physicians in training, and yet because of a lack of existing RFS policy specifically addressing the issue, they have no clear directive. GC Report B from I-15 ameliorated this issue by proposing a system wherein the RFS Caucus adheres strictly to RFS internal policy when applicable, but which allows it to speak on important resolutions not touched on in internal policy with the approval of a 2/3rds majority of an appropriately sized quorum of sectional delegates. The purpose of this report has been to detail all actions of the assembly with additional attention paid to caucus votes on items without previous RFS policy.

Three areas of interest to the RFS Caucus where internal RFS policy would likely be beneficial include topics pertaining to youth incarceration, women and Alzheimer’s disease, needle/syringe disposal, and DACA eligible medical professionals.

Conclusion
Our Resident and Fellow Section delegation to the House of Delegates performed outstanding work in Chicago this year by being outspoken advocates for the issues facing physicians in training today. Their testimony on their high priority items was heard in every arena - on the online member forums that have replaced formal virtual reference committees, in person at formal reference committees, and again on the floor of the House of Delegates itself. The flexibility afforded to the caucus by GC Report B allowed for the RFS’s voice to be heard on topics outside the scope of our formal Digest of Actions, and now presents us the above opportunities to add to our own policy.
# APPENDIX A: RFS Delegates & Endorsing Societies

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<tr>
<th>RFS-HOD Delegates</th>
<th>Endorsing Society</th>
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<tr>
<td>Naiim Ali, MD</td>
<td>Vermont Medical Society</td>
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<tr>
<td>Hans Arora, MD</td>
<td>American Urology Association</td>
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<td>John Corker, MD</td>
<td>American College of Emergency Physicians</td>
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<td>William Doetsch, MD</td>
<td>American Association of Neurological Surgeons</td>
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<td>Simon Faynboym, MD</td>
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<td>Sean Figy, MD</td>
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<tr>
<td>Laura Gephart, MD</td>
<td>Texas Medical Association</td>
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<td>Stephanie Howe Guarino, MD</td>
<td>Medical Society of Delaware</td>
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<tr>
<td>Shady Henien, MD</td>
<td>Connecticut State Medical Society</td>
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<tr>
<td>Sunny Jha, MD</td>
<td>American Society of Interventional Pain Physicians</td>
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<tr>
<td>Aaron Kithcart, MD, PhD</td>
<td>Massachusetts Medical Society</td>
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<tr>
<td>Steve Lee, MD</td>
<td>American Society of Clinical Oncology</td>
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<td>Casey Melcher, MD</td>
<td>Wisconsin Medical Society</td>
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<tr>
<td>Travis Meyer, MD</td>
<td>American College of Radiology</td>
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<td>Claire Murphy, MD</td>
<td>Washington State Medical Association</td>
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<td>Luke Selby, MD</td>
<td>Colorado Medical Society</td>
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<td>Megan Srinivas, MD</td>
<td>Maryland State Medical Society</td>
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<td>Vanessa Stan, MD</td>
<td>Illinois State Medical Society</td>
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<tr>
<td>Sarah Weaver, MD</td>
<td>Medical Society of Virginia</td>
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<td>Christopher Worsham, MD</td>
<td>Massachusetts Medical Society</td>
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### RFS-HOD Alt. Delegate Name

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<tr>
<th>RFS-HOD Alt. Delegate Name</th>
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<tr>
<td>Tyler Andre, MD</td>
<td>Michigan State Medical Society</td>
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<td>Kerri Chung, MD</td>
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<td>McKinley Glover, MD</td>
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<td>Jason Hall, MD, JD</td>
<td>American College of Medical Quality</td>
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<tr>
<td>Michael Knight, MD</td>
<td>Obesity Medicine Association</td>
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<td>Matthew Lecuyer, MD</td>
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<td>Sean Moran, MD</td>
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<td>Radiological Society of North America</td>
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<td>Californian Medical Association</td>
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<td>Laura Halpin, MD, PhD</td>
<td>American Psychiatric Association</td>
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<tr>
<td>Keshav Khanijow, MD</td>
<td>Maryland State Medical Society</td>
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<td>Samuel Mathis, MD</td>
<td>Texas Medical Association</td>
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<td>Matthew McNelley, MD</td>
<td>American Society of Anesthesiologists</td>
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<td>Ryan Ribeira, MD</td>
<td>Californian Medical Association</td>
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<td>Yusef Sayeed, MD, MPH, Meng, CPH</td>
<td>American College of Occupational and Environmental Medicine</td>
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<tr>
<td>Ujas Shah, MD</td>
<td>Medical Society of the State of New York</td>
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AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Informational Report: D (A-17)

Subject: AMA-RFS Sunset Mechanism Timing: Calendar v. Academic Year

Introduced by: RFS Governing Council

Background
The AMA-RFS is the largest organization of resident and fellow physicians in the United States. It was created by the AMA in 1974 to represent and advocate for resident and fellow. At the 1985 Interim Meeting, the American Medical Association-Resident and Fellow Section (AMA-RFS) Assembly adopted a report entitled, “Sunset of AMA-RFS Policy,” now detailed in our AMA-RFS policy 580.013R. This report established a mechanism to systematically review AMA-RFS actions ten years after their adoption and identify and rescind outmoded, irrelevant, duplicative, or inconsistent actions.

Calendar Year v. Academic Year
In previous years, the Informational Sunset Report has been published at the Annual Meeting with the Assembly voting on final recommendations at the following Interim Meeting, as it has been based on a calendar-year schedule. For example, an Informational Sunset Report was published at 2016 Annual Meeting and a Final Sunset Report was presented for Assembly vote at 2016 Interim Meeting. However, because the Governing Council member turnover is based on the academic calendar, the members who authored and reviewed the informational report that was published at Annual are no longer serving on the Governing Council when the final report is presented for Assembly vote at the following Interim Meeting.

To align the timing of the Sunset Reports with the tenure of the Governing Council members writing and reviewing them, we will present the Informational Sunset Report at this year’s 2017 Interim Meeting and the Final Sunset Report will be presented for Assembly vote at 2018 Annual. Future Sunset Reports will continue to follow this Academic Calendar with Informational Sunset Reports being published at Interim Meetings and Final Sunset Reports being presented to the Assembly for vote at the following Annual Meeting.

Review of Sunset Report Procedure, Consistent with the Academic Calendar
Following the AMA-RFS 2016 Annual Meeting, the RFS Sunset Mechanism procedure was reviewed to determine what revisions should be made in order to align with HOD Sunset Mechanism procedure. However, HOD does not have a codified procedure and was impressed with the current RFS procedure, as it provides consistency and is aligned with the intent of the Sunset Mechanism, as well as provides guidance on how to compensate for well-intentioned actions that should be rescinded because they are outmoded. The following is a review of the Sunset Report Procedures, which is now consistent with the Academic Calendar:

The appendix of the Sunset report contains two lists of the actions adopted by the Assembly ten years prior: those recommended for reaffirmation and those recommended for rescission. Since the final report will not allow for amendments to individual items within the report, an Informational Sunset Report will be published at Interim to provide the Assembly ample time to review the report recommendations. At the following Annual meeting, these lists will be divided.
into two separate reports, each to be handled in the manner of a consent calendar that can only be amended by the extraction of an item. If an item is extracted, the only motion that will be in order is to “rescind” or to “reaffirm” that item.

New resolutions can be submitted at the following meeting to compensate for well-intentioned actions that should be rescinded because they are outmoded. Any new resolution must stand on its own, separate from the Sunset Report. Your Governing Council will work with the Committee on Long Range Planning to submit new resolutions at the Annual Meeting, that are intended to compensate for the well-intended but outmoded policies that are recommended to “rescind”.

Any delegate may move to reaffirm an action recommended for rescission, or vice-versa, at the Annual Meeting. In order for the sunset mechanism to operate efficiently, it is important that each representative thoroughly review the Informational Sunset Report. Background information on any action is available upon request from the Department of Resident and Fellow Services.