AMA Resident and Fellow Section

Reports and Resolutions
American Medical Association - Resident and Fellow Section
2017 Interim Reports & Resolutions Handbook
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Memo to: AMA-RFS Assembly  
From: Matthew Lecuyer, MD  
AMA-RFS Chair  
Date: November 2017  
Subject: Items of Business before the RFS Reference Committee

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Whereas, Network adequacy is the concept that the number of physicians in any given specialty within an insurance network meets or exceeds the needs of the community it is intended to serve; and

Whereas, Health insurance providers are increasingly limiting patient choices of providers and facilities in their offerings in an attempt to contain costs; and

Whereas, Many plans on Affordable Care Act (ACA) exchanges offer only Health Maintenance Organizations (HMOs), exclusive provider organizations (EPOs) or other organization that limit provider and facility access; and

Whereas, These narrow/tiered networks adversely affect patient access to care; and

Whereas, Patients in narrow/tiered network plans are subject to excessive out-of-pocket costs for seeking out-of-network care, the costs of which are not subject to caps under ACA; and

Whereas, Patients who seek care outside of their narrow networks may be subject to balanced billing if their state does not preclude this; and

Whereas, The majority of patients and providers prefer broader choices with respect to providers and facilities; and

Whereas, Existing AMA Policy Health Insurance Safeguards H-285.911 states “health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis”; therefore be it

RESOLVED, That our AMA-RFS recognize network adequacy as a central element of access to care; and be it further

RESOLVED, That our AMA-RFS recognize that network adequacy must include emergency and psychiatric care; and be it further

RESOLVED, That our AMA-RFS work with interested sections and organizations to ensure that out-of-network policies do not limit access to care by creating undue financial and administrative burdens for patients and physicians.

Fiscal Note:

References:
1. 75% in one broad study by McKinsey in 2016 (FULL CITATION PENDING AUTHOR SUBMISSION)
2. Georgetown study (FULL CITATION PENDING AUTHOR SUBMISSION)
3. ref 19 within Georgetown study (FULL CITATION PENDING AUTHOR SUBMISSION)
4. Georgetown ref 21 (FULL CITATION PENDING AUTHOR SUBMISSION)

Relevant RFS and AMA Policy:

130.012R National Health Issues: That our Governing Council continue to review national health issues and ways in which the AMA-RFS could influence these issues, and report to the AMA-RFS Assembly as appropriate. (Resolution 19, A-78) (Reaffirmed Report C, I-88) (Reaffirmed Report C, I-98) (Reaffirmed Report D, I-16)

130.013R Physician Stewardship of Health Resources: That our AMA-RFS: 1) take the position that physicians have an ethical duty to be responsible stewards of health system resources and should seek to practice cost-conscious medicine when feasible while maintaining the primacy of the patient’s best interest; and 2) support and encourage efforts by academic institutions and accrediting bodies to improve residents’ and fellows’ education regarding cost-conscious medicine. (Resolution 7, A-12)

140.001R President Barack Obama’s Health Care Plan: That our AMA-RFS (1) continue to advocate for health system reform which makes health insurance coverage accessible for all U.S. citizens; (2) support the proposal to require all children to have health insurance as a strategic priority; (3) advocate for sufficient federal subsidy or tax credit amounts so that all U.S. citizens can afford to purchase health insurance; (4) support the proposed requirement for private insurers that children up to age 25 could continue family coverage through their parents’ plan; (5) work with the federal government to ensure that if federal programs are to be expanded, that proper checks and balances are in place to ensure that re-imbursements reflect the actual cost of care and that patient access is not limited; (6) ensure that under the National Health Insurance Exchange (or any similar proposed program) that participating insurers provide high quality, transparent services, and that their reimbursements reflect the actual cost of care; and (7) that our AMA support requiring all children to have health insurance as a strategic priority. (Report H, I-08)

140.003R Health Care as a Right for All Citizens of America: That our AMA assert that all people deserve access to quality, affordable, basic and preventative healthcare. (Substitute Resolution 11, A-07)

140.005R The Fundamental Importance of Universal Access: That our AMA-RFS (1) strongly assert that the fundamental goal of any change in the American health care system should be to move toward increased access to quality health care for every American citizen; and (2) accept access to high quality health care for all Americans as a clear guiding principle in evaluating and responding to proposals to change the American health care system. (Substitute Resolution 33, I-95) [See also: AMA Policy H-165.918, H-165.969] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

270.001R Promoting Patient Access to Established Physicians: That our AMA-RFS support: (1) direct patient access to physicians of their choice, regardless of whether the physician is a generalist or specialist; and (2) asking medical specialty organizations to develop guidelines for care provided according to specialty and to document the impact of the guidelines on the quality and cost-effectiveness of direct access to care. (Substitute Resolution 3, A-94) [See also: AMA Policy H-230.999, H-385.992, H-405.985] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
The Future of Emergency and Trauma Care D-130.971
Our AMA will: (1) expand the dialogue among relevant specialty societies to gather data and identify best practices for the staffing, delivery, and financing of emergency/trauma services, including mechanisms for the effective regionalization of care and use of information technology, teleradiology and other advanced technologies to improve the efficiency of care; (2) with the advice of specific specialty societies, advocate for the creation and funding of additional residency training positions in specialties that provide emergency and trauma care and for financial incentive programs, such as loan repayment programs, to attract physicians to these specialties; (3) continue to advocate for the following: a. Insurer payment to physicians who have delivered EMTALA-mandated, emergency care, regardless of in-network or out-of-network patient status, b. Financial support for providing EMTALA-mandated care to uninsured patients, c. Bonus payments to physicians who provide emergency/trauma services to patients from physician shortage areas, regardless of the site of service, d. Federal and state liability protections for physicians providing EMTALA-mandated care; (4) disseminate these recommendations immediately to all stakeholders including but not limited to Graduate Medical Education Program Directors for appropriate action/implementation; (5) support demonstration programs to evaluate the expansion of liability protections under the Federal Tort Claims Act for EMTALA-related care; (6) support the extension of the Federal Tort Claims Act (FTCA) to all Emergency Medical Treatment and Labor Act (EMTALA) mandated care if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by such extension; and (7) if an evaluation of a demonstration program, as called for in AMA Policy D-130.971(5), shows evidence that physicians would benefit by extension of the FTCA, our AMA will conduct a legislative campaign, coordinated with national specialty societies, targeted toward extending FTCA protections to all EMTALA-mandated care, and the AMA will assign high priority to this effort. (BOT Rep. 14, I-06; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17)

Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services D-130.975
Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status. (BOT Rep. 2, I-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17)

Price Transparency D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.

7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments. (CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16)

Out-of-Network Care D-285.962
Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care. (Res. 108, A-17)

Tiered, Narrow, or Restricted Physician Networks D-285.972
Our AMA will:
(1) seek to have third party payers disclose, in plain language, the criteria by which the carrier creates a tiered, narrow or restricted network;
(2) monitor the development of tiered, narrow or restricted networks to ensure that they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on the potential for a limited number of specialists in the resulting network(s); and
(3) seek legislation or regulation which prohibits the formation of networks based solely on economic criteria and ensures that, before health plans can establish new panel networks, physicians are informed of the criteria for participating in those networks, with sufficient advance time to permit them to satisfy the criteria. (Res. 806, I-06; Reaffirmed in lieu of Res. 729, A-08; Reaffirmation I-10; Reaffirmed in lieu of Res. 815, I-13; Reaffirmation A-14; Reaffirmed: CMS Rep. 4, I-14; Reaffirmation I-15)

Basic Health Program H-165.832
1. Our AMA supports the adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote the continuity and coordination of patient care.

2. Our AMA adopts the following principles for the establishment and operation of state Basic Health Programs:
A. State Basic Health Programs (BHPs) should guarantee ample health plan choice by offering multiple standard health plan options to qualifying individuals. Standard health plans offered within a BHP should provide an array of choices in terms of benefits covered, cost-sharing levels, and other features.
B. Standard health plans offered under state BHPs should offer enrollees provider networks that have an adequate number of contracted physicians and other health care providers in each specialty and geographic region.
C. Standard health plans offered in state BHPs should include payment rates established through meaningful negotiations and contracts.
D. State BHPs should not require provider participation, including as a condition of licensure.
E. Actively practicing physicians should be significantly involved in the development of any policies or regulations addressing physician payment and practice in the BHP environment.
F. State medical associations should be involved in the legislative and regulatory processes concerning state BHPs.
G. State BHPs should conduct outreach and educational efforts directed toward physicians and their patients, with adequate support available to assist physicians with the implementation process. (CMS Rep. 5, A-12)

**Physician Penalties for Out-of-Network Services H-180.952**
Our AMA vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services. (Res. 702, A-07; Reaffirmed: CMS Rep. 01, A-17)

**Out-of-Network Care H-285.904**
Our AMA adopts the following principles related to unanticipated out-of-network care:

1. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

7. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

8. Mediation should be permitted in those instances where a physician’s unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard. (Res. 108, A-17)

**Protecting Against Forced Network Exclusivity of Specialist Physicians H-285.906**
Our AMA supports allowing specialty physicians to have primary contract status in more than one network. (Sub. Res. 711, A-15)

**Network Adequacy H-285.908**
1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.

2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.

3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.

4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.

5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.

6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.

7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.

8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.

9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.

10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.

11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible. (CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17)

Health Insurance Safeguards H-285.911

Our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (CMS Rep. 8, A-10; Reaffirmed in lieu of Res. 815, I-13; Reaffirmation I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17)
Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks H-450.941

1. Our AMA will collaborate with interested parties to develop quality initiatives that exclusively benefit patients, protect patient access, do not contain requirements that permit third party interference in the patient-physician relationship, and are consistent with AMA policy and Code of Medical Ethics, including Policy H-450.947, which establishes the AMA's Principles and Guidelines for Pay-for-Performance and Policy H-406.994, which establishes principles for organizations to follow when developing physician profiles, and that our AMA actively oppose any pay-for-performance program that does not meet all the principles set forth in Policy H-450.947.

2. Our AMA strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors.

3. Our AMA pledges an unshakable and uncompromising commitment to the welfare of our patients, the health of our nation and the primacy of the patient-physician relationship free from intrusion from third parties.

4. Because there are reports that pay-for-performance programs may pose more risks to patients than benefits, our AMA will prepare an annual report on the risks and benefits of pay-for-performance programs, in general and specifically the largest programs in the country including Medicare, for the House of Delegates over the next three years, beginning at the 2007 Interim Meeting. This report should clearly delineate between private pay-for-performance programs and voluntary public pay-for-reporting and other related quality initiatives.

5. Our AMA will continue to work with other medical and specialty associations to develop effective means of maintaining high quality medical care which may include physician accountability to robust, effective, fair peer review programs, and use of specialty-based clinical data registries.

6. As a step toward providing the Centers for Medicare and Medicaid Services (CMS) with data on special populations with higher health risk levels and developing variable incentives in achieving quality, our AMA will continue to work with CMS to encourage and support pilot projects, such as the Physician Quality Reporting Initiative (PQRI), by state and specialty medical societies that are developed collaboratively to demonstrate effective incentives for improving quality, cost-effectiveness, and appropriateness of care.

7. Our AMA will advocate that physicians be allowed to review and correct inaccuracies in their patient specific data well in advance of any public release, decreased payments, or forfeiture of opportunity for additional compensation. (BOT Rep. 18, A-07; Reaffirmed in lieu of Res. 729, A-08; Reaffirmation A-09; Reaffirmed: BOT Rep. 18, A-09; Reaffirmation I-10; Reaffirmed in lieu of Res. 808, I-10; Reaffirmed in lieu of Res. 824, I-10; Reaffirmed: BOT Action in response to referred for decision Res. 816, I-16)
Resolution: 1
(I-17)

Introduced by: Kunj Patel, MD MSc; Naiim Ali, MD

Subject: Regulating Tattoo and Permanent Makeup Inks

Referred to: Reference Committee

Whereas, Almost a fourth of men and women between the age of 18 and 50 currently have a
tattoo\(^1\); and

Whereas, The FDA regulates cosmetics, which are generally pigments used on the surface of
the skin, but does not regulate tattoo and permanent makeup inks which are pigments injected
with needles below the skin's surface\(^2\); and

Whereas, Some risks, such as the spread of infections through the use of unsterilized needles,
have long been known\(^2\); and

Whereas, The long term safety of permanent tattoo inks has not been previously studied\(^2\); and

Whereas, Research has also shown that some pigment migrates from the tattoo site to the
body's lymph nodes\(^2\); and

Whereas, Many pigments used in tattoo inks are industrial-grade colors suitable for printers' ink
or automobile paint\(^2\); and

Whereas, Azo pigments, the organic pigments making up about 60% of the colorants in tattoo
inks are not of health concern while chemically intact, they can degrade with the help of bacteria
or ultraviolet light and potentially can turn into cancer-causing primary aromatic amines; and

Whereas, Some surveys show that up to 50% of tattoo owners come to regret getting a tattoo;
and

Whereas, Lasers are often used to blast apart pigments, sending problematic degradation
products into the body and researchers do not know how the degradation products are
distributed in the body or how they get excreted; and

Whereas, A study by the Australian government's National Industrial Chemical's Notification
and Assessment Scheme (NICNAS) showed the presence of polycyclic aromatic hydrocarbons
(PAHs), a group of chemicals known to be carcinogens in more than one-fifth of 49 inks tested
and in 83% of the black inks tested\(^3\); and

Whereas, Tattoo inks may also contain potentially harmful metal impurities such as chromium,
nickel, copper, and cobalt; and

Whereas, Manufacturers of tattoo and permanent makeup inks in the United States are often
protected from divulging the ingredients of tattoo inks under the guise of considering them
'trademark secrets'; and
Whereas, In 2008, the Council of Europe, an organization focused on promoting human rights and the integration of regulatory functions in the continent, recommended policies to ensure the safety of tattoos and permanent makeup, which advocate the banning of sixty-two hazardous chemicals, as well as guidelines which include that Tattoo and permanent makeup products should contain the following information on the packaging: the name and address of the manufacturer or the person responsible for placing the product on the market, the date of minimum durability, the conditions of use and warnings, the batch number or other reference used by the manufacturer for batch identification, the list of ingredients according to their International Union of Pure and Applied Chemistry (IUPAC) name, CAS number (Chemical Abstract Service of the American Chemical Society) or Colour Index (CI) number, and the guarantee of sterility of the contents; and

Whereas, Our AMA policy Regulation of Tattoo Artists and Facilities H-440.909 currently only encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health, and encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program; and

Whereas, Current regulation of tattoo and permanent makeup inks in the United States performed at state or provincial levels generate a wide variety of guidelines and hygiene standards; therefore it be

RESOLVED, That our AMA encourage the Food and Drug Administration (FDA) to adopt regulatory standards for tattoo and permanent makeup inks that include at minimum the disclosures expected for injectable drugs and cosmetics and mandate that this information be available to both the body licensed to perform the tattoo and to the person receiving the tattoo; and be it further

RESOLVED, That our AMA encourage the FDA to ban from tattoo and permanent makeup inks any chemical for which significant concern exists with regard to their carcinogenic, mutagenic, reprotoxic, and sensitizing properties.

Fiscal Note:

References:

Relevant RFS and AMA Policy:
150.998R Truth in Nutrition Labeling
Asked that the AMA-RFS ask the AMA to support and advocate for changing FDA policy to require manufacturers to include levels of trans fatty acids on the “nutrition facts” portion of food labels; and (2) That the AMA-RFS ask the AMA to support and advocate for the development of guidelines for labeling foods as “low fat” and “low cholesterol” which include levels of trans fatty acids. (Substitute Resolution 9, I-96) (Reaffirmed Report C, I-06)

Regulation of Tattoo Artists and Facilities H-440.909
The AMA encourages the state regulation of tattoo artists and tattoo facilities to ensure adequate procedures to protect the public health; and encourages physicians to report all adverse reactions associated with tattooing to the Food and Drug Administration MedWatch program. (Res. 506, A-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16)

Adequacy of Sterilization in Commercial Enterprises H-440.934
The AMA requests that state health departments ensure the adequacy of sterilization of instruments used in commercial enterprises (tattoo parlors, beauty salons, barbers, manicurists, etc.) because of the danger of exchange of infected blood-contaminated fluids. (Sub. Res. 409, I-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)
Whereas, The rate of suicide completion among medical professionals exceeds that of the combined U.S. population; and

Whereas, Suicides among physicians are perceived as isolated events\(^1\); and

Whereas, Job stress is an independent risk factor for physician suicide\(^2\); and

Whereas, More understanding is needed about what systemic factors lead physicians to suicide; and

Whereas, Current AMA policy addresses a physician’s or student’s responsibility to seek mental health care, and encourages confidential reporting of risk factors by medical students, but does not include consequences for institutions that do not work to prevent suicide; and

Whereas, Work conditions beyond resident work hours, such as bullying, can contribute to suicide\(^3\); and

Whereas, Media coverage of physician suicide has increased dramatically in the past year; therefore be it

RESOLVED, That our AMA recommend that the Liaison Committee on Medical Education investigate conditions and circumstances at any medical school or residency program that has experienced a suicide to identify patterns that could predict such events.

Fiscal Note:

References:
Relevant RFS and AMA Policy:

240.014R Psychotherapy for Medical Students and Residents
Recommended (1) that the RFS seek updated information from each state medical licensing board on its requirements for reporting mental health treatment or psychotherapy, and (2) that the RFS publish this information along with a reiteration of current AMA policy on reporting requirements for physicians who have received any form of psychiatric treatment in Code Blue and Resident Forum. This information can then be used by residents in conjunction with their state medical societies to effect regulatory change in the requirements for medical licensure. (Report C, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-16)

Access to Confidential Health Services for Medical Students and Physicians H-295.858
1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship programs, respectively, to:

A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;

B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;

C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and

D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.

2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.

3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:

A. be available to all medical students on an opt-out basis;

B. ensure anonymity, confidentiality, and protection from administrative action;
C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and

D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.

4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages 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.

5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education. (CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17)
Whereas, Residency programs determine the promotion and board eligibility of trainees; and

Whereas, Residency programs currently report completion of each year of training as either a full year or zero credit; and

Whereas, Residents may have successfully completed several rotations in a year before not passing a rotation; and

Whereas, Residency programs may disavow a resident’s successfully completed rotations as a form of retroactive retaliation; and

Whereas, Residents may have to leave a program mid-year for health or other reasons; and

Whereas, GME funds are limited; and

Whereas, GME funds are traditionally issues in one-year increments; and

Whereas, Repetition of successfully completed residency training months delays graduation of physicians exacerbates the nation’s physician shortage and wastes GME funds; and

Whereas, Residents with interrupted training and a lack of options are compelled to retrain in “any specialty” thereby filling entry-level positions and repeating years of training, also wasting GME funds; and

Whereas, Residents who so repeat training are doing so at the expense of other unmatched graduates who need training; and

Whereas, Resident physicians will be more competitive for employment if they are able to present an accurate representation of rotations completed; therefore be it

RESOLVED, That our AMA advocate that all residency programs report passing of rotations on a monthly basis to specialty boards; and be further

RESOLVED, That our AMA advocate that all residency programs document passing of rotations on a monthly basis directly to residents; and be it further

RESOLVED, That our AMA advocate for a partial-year option for GME funding from the U.S. government to support residents.

Fiscal Note:
References:
1. http://www.acgme.org/WhatWeDo/Accreditation/SingleGMEAccreditationSystem/ResidentFellowEligibility
2. https://www.abp.org/content/residentsfellowsevaluationtracking

Relevant RFS and AMA Policy:

240.012R Postgraduate Training Requirements for Obtaining Permanent Medical Licensure
That our AMA (1) reaffirm existing policy urging state medical licensing boards to permit graduates of Liaison Committee on Medical Education accredited programs to be licensed for the independent practice of medicine prior to the second year of residency training; and (2) reaffirm opposition to lengthy periods of residency training as part of the requirements for licensure, as tending toward licensure by specialty. (Report J, I-88) (Reaffirmed Report C, I-98) (Reaffirmed Report D, I-16)
Whereas, The demands of studying for a board exam and adjusting to the first year of clinical practice after residency present a major challenge for young physicians; and

Whereas, Time away from one's practice to take and study for a board exam presents a strain on patients and the other physicians in a practice; and

Whereas, More than one out of every ten internal medicine resident fails the ABIM examination on the first attempt and needs to retake the exam; and

Whereas, Residents may wait years before completing residency after an interruption due to illness, pregnancy, death in the family or other cause; and

Whereas, Residents are best equipped to do well on their first board exams while most recently exposed to didactic lectures in residency; and

Whereas, Two distinct and unrelated factors--residency graduation and oral and/or written board exam passing--are required for board certification; and

Whereas, Steps one and two of the National Board exams do not require graduation from medical school; and

Whereas, Step three of the National Board exam does not require graduation from internship; and

Whereas, Residents face intense competition for off-cycle residency slots; and

Whereas, Passing of a board exam may help physicians to compete for a new residency slot after an absence; and

Whereas, Inability to take a board exam may lead a well-qualified physician to stop pursuing medicine or residency completion; and

Whereas, Certifying boards retain the right to withhold the term "board certification" until a residency diploma is obtained; therefore be it

RESOLVED, That our AMA advocate for the right of medical residents to sit for specialty board exams at any time any year of their choosing during officially schedules administrations; and be it further

RESOLVED, That our AMA recommend that the specialty board exam, written and oral for those specialties with oral exams, be considered "Step 1" of a two-part process in credentialing.
References:

Relevant RFS and AMA Policy:

240.012R Postgraduate Training Requirements for Obtaining Permanent Medical Licensure
That our AMA (1) reaffirm existing policy urging state medical licensing boards to permit graduates of Liaison Committee on Medical Education accredited programs to be licensed for the independent practice of medicine prior to the second year of residency training; and (2) reaffirm opposition to lengthy periods of residency training as part of the requirements for licensure, as tending toward licensure by specialty.

240.016R Right of a Resident to Practice Medicine within Scope of Practice and Maintain Board Certification
That our AMA oppose the establishment of scope of practice limitations through use of board certifications by the American Board of Medical Specialties and its member organizations. (Late Resolution 1, A-14)

250.005R Preserving Residency Training and Board Certification
That our AMA-RFS support: (1) policy to remove board certification as a requirement for enrollment in managed care contracts and to pursue with the insurance industry alternatives to board certification for quality non-boarded physicians; (2) the AMA's continued study of alternatives to board certification; and (3) continuation of the requirement of both residency training and a passing score on a board exam in the appropriate specialty for board certification. (Substitute Resolution 4, I-95) [See also: AMA Policy H-275.944] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

291.010R Impact of Specialty Board Mandated Residency Completion Dates on Parental Leave During Residency
In order to accommodate leave protected by the federal Family and Medical Leave Act (FMLA), the AMA encourage all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year. (Resolution 2, A-09)

Medical Licensure H-275.978
The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;
(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;
(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;

(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);

(7) urges licensing boards to maintain strict confidentiality of reported information;

(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;

(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;

(10) urges all physicians to participate in continuing medical education as a professional obligation;

(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;

(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;

(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;

(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;

(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;

(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;

(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;

(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;

(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;

(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement;

(21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and

(22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. (CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10; Reaffirmed: CME Rep. 6, A-12; Appended: Res. 305, A-13; Reaffirmed: BOT Rep. 3, I-14)

Recommendations for Future Directions for Medical Education H-295.995

Our AMA supports the following recommendations relating to the future directions for medical education:

(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.

(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.

(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.

(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.

(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.

(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.

(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.

(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.

(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.

(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.

(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.
(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the “General Requirements” section of the “Essentials of Accredited Residencies.” (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.

(30) U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME.
(31) Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine.

(32) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(33) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(35) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(36) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.


**Principles for Graduate Medical Education H-310.929**

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

(1) **PURPOSE OF GRADUATE MEDICAL EDUCATION.** There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

(2) **RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.** Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) **EDUCATION IN THE BROAD FIELD OF MEDICINE.** GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) **SCHOLARLY ACTIVITIES FOR RESIDENTS.** Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.
(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

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

Resolution: 5
(I-17)

Introduced by: Darian Esfahani, MD; Scott Leikin, DO;

Subject: The Intracranial Hemorrhage Anticoagulation Reversal (ICHAR) Initiative

Referred to: Reference Committee

Whereas, Cerebrovascular disease is the fifth most common cause of mortality in the United States, responsible for 5.2% of deaths nationwide or 140,000 per year

Whereas, Intraparenchymal hemorrhages are the most common nontraumatic hemorrhagic stroke and have the highest risk of mortality; and

Whereas, The largest reversible risk factor for poor outcomes in intraparenchymal hemorrhages is use of anticoagulants, such as warfarin; and

Whereas, The effects of anticoagulants can be mitigated with rapid use of newer reversal agents, such as prothrombin complex concentrate, which have replaced transfusion as a standard of care; and

Whereas, Many emergency rooms do not know about new anticoagulation reversal medications or do not know how to use them, resulting in worse outcomes for patients prior to transfer to tertiary centers; and

Whereas, Savings in healthcare expenditures and worker productivity are expected with better patient outcomes, while reversal medications are relatively inexpensive; therefore be it

RESOLVED, That the AMA-RFS support initiatives and legislation in the US Congress to promote the use of anticoagulation reversal medications up to date with the most current nationally recognized, evidence based stroke guidelines for patients with intracranial hemorrhage; and be it further

RESOLVED, That the AMA-RFS support initiatives and legislation in the US Congress adding requirements for stroke centers and high-stroke volume hospitals to carry and use anticoagulation reversal agents or risk penalties determined by the appropriate supervising bodies; and be it further

RESOLVED, That the AMA support studying ways to improve and reduce the barriers to the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening clinical indications.

Fiscal Note:

References:

Relevant RFS & AMA Policy:

**Home Anti-Coagulation Monitoring H-185.951**
1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anti-coagulation for all medically appropriate conditions.

2. Our AMA (a) supports the appropriate use of home self-monitoring of oral anticoagulation therapy and (b) will continue to monitor safety and effectiveness data, in particular cost-effectiveness data, specific to the United States on home management of oral anticoagulation therapy.

3. Our AMA will request a change in Centers for Medicare & Medicaid Services’ regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions. (Res. 825, I-05; Modified and Reaffirmed: CSAPH Rep. 9, A-07; Appended: Res. 709, A-14)

**Stroke Prevention and Care Legislation H-425.978**
Our AMA supports comprehensive stroke legislation such as S.1274, the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act) as introduced, and work with Congress to enact legislation that will help improve our nation’s system of stroke prevention and care. (Res. 215, I-01; Reaffirmed: BOT Rep. 22, A-11)

**The Next Transformative Project: In Support of the BRAIN Initiative H-460.904**
Our AMA: (1) supports the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process; (2) encourages appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the BRAIN Initiative; and (3) supports the continued Congressional allocation of funds for the BRAIN Initiative, thus providing for research and innovation in technologies that will advance knowledge of neurologic function and disease. (Res. 522, A-13; Modified: Res. 514, A-15)
Whereas, Parental leave during residency is protected by the Federal Family and Medical Leave Act (FMLA), our AMA-RFS encourage a 12-week training extension, in lieu of repeating a year upon returning from a qualified leave by FMLA, across all the specialties within the American Board of Medical Specialties provided that resident maintain board eligibility in that year (see 291.010R, 291.012R); and

Whereas, Our AMA-RFS deplore penalizing residents for appropriate sick leaves if within the parameters of the Accreditation Council of Graduate Medical Education (ACGME) and Residency Review Committee (RRC) requirements (see 291.031R); and

Whereas, Our AMA-RFS recognize resident abuse as a valid concern and encourages further research on that matter. Our AMA-RFS also support vocational, personal and educational benefits of residents. In that context, our AMA-RFS detest any inappropriate institutional action that would threaten the career of a resident physician (see 291.033R, 291.034R, 292.006R); and

Whereas, ACGME prohibits the use of formative assessment in penalizing residents including training extension beyond traditional residency completion dates as published in the ACGME program director guide to the common program requirement1; therefore be it

RESOLVED, That our AMA asks the specialty boards to reaffirm institutional criteria for extending residency not to include making-up sick leaves within the parameters specified by ACGME or penalizing residents for poor formative assessment.

Fiscal Note:

References:

Relevant RFS and AMA Policy:

R-291.010R Impact of Specialty Board Mandated Residency Completion Dates on Parental Leave During Residency
In order to accommodate leave protected by the federal Family and Medical Leave Act (FMLA), the AMA encourage all specialties within the American Board of Medical Specialties to allow
graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year. (Resolution 2, A-09)

R-291.012R Loss of Status Following Family Medical Leave Act (FMLA) Qualified Leave During Residency Training
That our AMA: (1) oppose requiring residents to repeat a year of training when returning to work following a leave that qualifies under the federal Family Medical Leave Act; and (2) urge the American Board of Medical Specialties and its member boards to be in compliance with the Family Medical Leave Act and to retract any policies that do not comply. (Resolution 2, I-07)

R-291.031R Sick Leave for Resident Physicians
That our AMA-RFS: (1) deplore the inappropriate use of sick leave in the workplace; and (2) support a policy which would allow a resident to be absent for illness or surgery for a reasonable period of time without being penalized, within the parameters of the Accreditation Council of Graduate Medical Education (ACGME) and Residency Review Committee (RRC) requirements. (Substitute Resolution 2, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

R-291.033R Recognition and Definition of Resident Abuse
That: (1) our AMA-RFS recognize resident abuse as a valid issue and apply the definition established for medical student abuse to residents; and (2) that the AMA support further research on medical student and resident abuse. (Substitute Resolution 17, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

R-291.034R Residents' Benefits
That our AMA-RFS continue to formulate long range plans and strategies to improve the vocational, personal and educational benefits of residents. (Substitute Resolution 1, A-81) (Reaffirmed Report C, I-91) (Reaffirmed Report C, I-01)

R-292.006R Due Process for Housestaff in All Loss-of Employment Situations
That our AMA-RFS support proposed modifications to the ACGME Institutional Requirements that would expand the provision of a grievance process to situations including non-renewal of contract and other actions that would threaten the career of a resident physician. (Substitute Resolution 2, A-00) (Reaffirmed Report C, I-10)

CMS to Pay for Residents? Vacation and Sick Leave D-305.968
Our AMA will lobby the Centers for Medicare and Medicaid Services to continue to reimburse the direct and indirect costs of graduate medical education for the time resident physicians are on vacation or sick leave. (Res. 321, A-07; Reaffirmed: CME Rep. 01, A-17)

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order...
to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.

3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship. (CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14)

Paid Sick Leave H-440.823
Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome. (CMS Rep. 03, A-16)
Resolution: 7
(I-17)

Introduced by: Rebecca C. Obeng, MD PhD MPH; Joseph Sanfrancesco, MD FCAP; Abha Soni, DO MPH; Sounak Gupta, MBBS PhD; Diana Murro Lin, MD; H. Clifford Sullivan, MD FASCP; Cody Carter, MD

Subject: Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows

Referred to: Reference Committee

Whereas, Laboratory tests are the single highest volume medical activity that is vital for diagnostic and therapeutic decisions and patient care and often leads to additional downstream interventions and costly care; and

Whereas, Medical errors including inappropriate use of laboratory tests are the third leading cause of death in the United States and lead to preventable morbidity and mortality; and

Whereas, Appropriate laboratory test utilization can reduce healthcare costs and improve quality of care; and

Whereas, The Centers for Disease Control and Prevention and other studies have found that poor knowledge and inappropriate use of laboratory tests by physicians is due in part to the lack of formal training during medical school; and

Whereas, The Institute of Medicine supports enhanced training in diagnostic processes for healthcare professionals; and

Whereas, The clinical applications of pathology and laboratory medicine are not a required clerkship in nearly half of all medical schools in the United States or are fragmented and poorly integrated into medical school curriculums; and

Whereas, One third of medical school program directors express concern about the inadequate understanding of pathophysiology concepts by medical students; and

Whereas, Consensus guidelines for clinical competencies and education in pathology and laboratory medicine have been established and recommended by the Association of Pathology Chairs and other leading pathologists in academic institutions and organizations; therefore be it

RESOLVED, That our AMA strongly support the preservation of the incorporation of the clinical practice of pathology and laboratory medicine into integrated undergraduate and specialty-tailored graduate medical education; and be it further

RESOLVED, That our AMA, in collaboration with other entities invested in medical education, provide educational resources, including guidelines for competencies in pathology and laboratory medicine for medical student, resident and fellow members.
References:

10. Laposata M, Putting the patient first--using the expertise of laboratory professionals to produce rapid and accurate diagnoses. Lab Med 2014;45:4-5.

Relevant RFS & AMA Policy:

260.010R Clinical Skills Assessment as Part of Medical School Standards: That given the importance of assessing clinical competency, the AMA strongly urge the LCME and AOA modify its accreditation standards to require that medical schools administer a rigorous and standardized assessment of clinical skills to all students as a requirement for advancement and graduation; and that the AMA amend HOD Policy H-275.956 by deletion and addition to read:
H-275.956 Demonstration of Clinical Competence
It is the policy of the AMA to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) oppose the use of these methods in evaluation for licensure of graduates of LCME- and AOA-accredited medical schools, believing that clinical skills assessment is best performed using a rigorous and standardized examination administered by the medical school. (RFS Emergency Resolution 1, I-02; Reaffirmed Report D, I-12)

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317
1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients.

2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation.

3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents’ compensation and lifetime earnings. (CME Rep. 3, A-14; Appended: CME Rep. 04, A-16)

Patient Safety Curricula in Undergraduate Medical Education D-295.942
1. Our AMA will explore the feasibility of asking the Liaison Committee on Medical Education to encourage the discussion of basic patient safety and quality improvement issues in medical school curricula.

2. Our AMA will encourage the Liaison Committee on Medical Education to include patient safety and quality of patient care curriculum within the core competencies of medical education in order to instill these fundamental skills in all undergraduate medical students. (Res. 801, I-07; Appended: Res. 320, A-1)

Voluntary Health Care Cost Containment H-155.998
(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care. (Res. 34, A-78; Reaffirmed: CLRDP Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12)

Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians H-295.864
Our AMA: (1) supports the availability of educational resources and elective rotations for medical students and resident/fellow physicians on all aspects of systems-based practice, to improve awareness of and responsiveness to the larger context and system of health care and to aid in developing our next generation of physician leaders; (2) encourages development of model guidelines and curricular goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and specialty societies, and explore developing an educational module on this topic as part of its Introduction to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical education accrediting bodies consider incorporation into their requirements for systems-based practice education such topics as health care policy and patient care advocacy; insurance, especially pertaining to policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and Medicaid; the physician’s role in obtaining affordable care for patients; cost awareness and risk benefit analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and improve patient care quality; and identification of system errors and implementation of potential systems solutions for enhanced patient safety and improved patient outcomes. (Sub. Res. 301, A-13; Reaffirmation I-15; Reaffirmed in lieu of: Res. 307, A-17)

Recommendations for Future Directions for Medical Education H-295.995

Our AMA supports the following recommendations relating to the future directions for medical education: (1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty. (2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable. (3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals. (4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students. (5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician. (6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling. (7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication. (8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose. (9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions. (10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs. (11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine. (12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of
where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomats.
(25) Specialty boards should consider having members of the public participate in appropriate board activities.
(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.
(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.
(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.
(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.
(30) U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME.
(31) Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine.
(32) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.
(33) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.
(34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.
(35) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.
(36) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.
Resident Education in Laboratory Utilization H-310.960
Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. (Res. 84, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)

Improving Genetic Testing and Counseling Services H-480.944
Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes. (Res. 913, I-16)
Whereas, The Association of American Medical Colleges (AAMC) is currently piloting a new, mandatory Standardized Video Interview (SVI) for students applying to emergency medicine residency programs; and

Whereas, The SVI requires students to provide video-taped responses to six questions intended to evaluate a student’s professionalism and interpersonal/communication skills, each displayed for 30 seconds, and have as many as 3 minutes to respond to each question; and

Whereas, During the pilot, videos will be scored by third-party trained raters, yet the AAMC expects that human review would likely be replaced by computer-based analysis should the SVI expand to other specialties; and

Whereas, The AAMC has yet to demonstrate that computer-based analysis of video-responses is non-inferior to human rating; and

Whereas, The AAMC working group that evaluated the voluntary pilot did not include medical students; and

Whereas, The AAMC reports that the research pilot showed that the SVI “measures something different than academic competency,” but was unable to demonstrate correlation between SVI scores and residency placement, performance in residency or performance in the target competencies; and

Whereas, The AAMC has not provided any estimate of costs or information regarding who would pay for this program should the SVI continue beyond its operational pilot; and

Whereas, No data is available to demonstrate that the SVI will not discriminate against underrepresented minority (URM), LGBTQ, non-native English speakers and other students who may be adversely affected by implicit bias during the residency application process; therefore be it

RESOLVED, That our AMA and AMA-RFS support proposed changes to residency and fellowship application requirements only when those changes have been evaluated by working groups which have students and residents as representatives, there is data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, there is data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds, and the costs to medical students and residents are mitigated; and be it further
RESOLVED, That our AMA and AMA-RFS oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met; and be it further

RESOLVED, That our AMA and AMA-RFS continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

Fiscal Note:

References:


Relevant RFS & AMA Policy:

260.003R NRMP All-In Policy: That our AMA does not support the current “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process. Also asked that the AMA work with the NRMP, and other external bodies (1) to revise match policy, including the secondary match or scramble process to create more standardized rules for all candidates and (2) to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants. (Report F, A-11)

294.010R Fellowship Application Reform: That our AMA: (1) working with specialty societies, support the development of a standardized application and selection process for each fellowship training specialty, specifically to simply the process of application for subspecialty training; and that (2) ensure that residents are allowed adequate exposure to subspecialty training prior to the initiation of the fellowship application process. (Resolution 1, A-04) (Reaffirmed Report D, I-14) [See also AMA HOD Resolution 323, A-04]

Clinical Skills Assessment During Medical School D-295.988

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills.

2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.
3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation's medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.

4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills.

5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed.

6. Our AMA encourages development of a post-examination feedback system for all USMLE test-takers that would: (a) identify areas of satisfactory or better performance; (b) identify areas of suboptimal performance; and (c) give students who fail the exam insight into the areas of unsatisfactory performance on the examination.


National Resident Matching Program Reform D-310.977

Our AMA: 

(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;

(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;

(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;

(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;

(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;

(6) does not support the current the “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;

(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;

(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;

(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not
filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;

(10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;

(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;

(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;

(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;

(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;

(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;

(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and


**Technology and the Practice of Medicine G-615.035**  
Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine. (Res. 606, A-14)

**Educating Competent and Caring Health Professionals H-295.975**  
(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.
(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants’ extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.

(3) Faculty of programs of education for the health professions must continue to emphasize that they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.

(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: CME Rep. 01, A-17)

Residents and Fellows’ Bill of Rights H-310.912

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

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows’ Bill of Rights.

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

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

6. Our AMA adopts the following ‘Residents and Fellows’ Bill of Rights’ as applicable to all resident and fellow physicians in ACGME-accredited training programs:
RESIDENTS AND FELLOWS’ BILL OF RIGHTS

Residents and fellows have a right to:

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

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

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

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

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

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

D. A safe and supportive workplace with appropriate facilities.

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

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

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

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences.
(3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act.

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

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

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

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

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

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey. (CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16)

Residency Interview Costs H-310.966

1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.

2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews. (Res. 265, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10; Appended: Res. 308, A-15)

Residency Interview Schedules H-310.998

Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants’ schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application. (Res. 93, I-79; Reaffirmed: CLRPD Rep. B, I-89; Appended: Res. 302 and Res. 313, I-97; Reaffirmed: CME Rep. 2, A-07; Modified: Res. 302, A-14)
Resolution:  9  
(I-17)

Introduced by:    Joseph Lee, MD; Adriana Coleska, MD
Subject:    Preventing Automobile Heat Stroke Deaths
Referred to:    Reference Committee

Whereas, Over 800 children have died from heat strokes while trapped in cars since 1990  
(averaging around 37 per year); and

Whereas, In over 55% of the cases the caregiver forgot the child in the vehicle, in 28% of cases  
the child entered an unattended vehicle and in 87% of the cases the child in question was under  
three years of age; and

Whereas, 80% of the increase in temperature occurs in the first ten minutes and cases have  
been reported in temperatures as low as 60 degrees Fahrenheit; and

Whereas, On June 7th 2017 U.S. Representatives Tim Ryan (D-13th OH), Peter King (R-2nd  
NY) and Jan Schakowsky (D-9th IL) introduced the Helping Overcome Trauma for Children  
Alone in Rear Seats Act (HOT CARS Act), a critical piece of legislation that would prevent  
children from being needlessly killed and injured when unknowingly left alone in vehicles that  
have already received widespread support from more than twenty of the nation’s leading public  
health, consumer and safety organizations, along with families who have lost their child or were  
seriously injured due to child vehicular heatstroke, which require cars to come equipped with  
technology to alert drivers if a child is left in the back seat once the car is turned off and was  
further introduced to the Senate by Senators Richard Blumenthal (D-CT) and Al Franken (D-  
MN) on July 31st 201745; and

Whereas, Such technology already exists and is available in some vehicles, including new GM  
and Nissan models. Further, aftermarket products also exist. While both technologies already  
exist, neither are widely implemented; therefore be it

RESOLVED, That our AMA support the passage of legislature in the House of Representatives  
and the Senate that will help prevent unnecessary injury or death of a child as a result of a  
vehicular heatstroke; and be it further

RESOLVED, That our AMA support the requirement of cars to come equipped with technology  
to alert drivers if a child is left in the back seat once the car is turned off.

Fiscal Note:

References:

Relevant RFS & AMA Policy:

Auto Heat Deaths H-15.949
Our American Medical Association supports efforts to reduce deaths of children left in unattended vehicles. (Res. 417, A-15)

Automobile Entrapment H-15.957
The AMA encourages automobile manufacturers to address concerns about entrapment in automobiles caused by electrical failure due to fire, water damage, accident or other causes, particularly as such failure may make electric windows or door locks inoperable. (Sub. Res. 414, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17)

Automobile-Related Injuries H-15.990
Our AMA:
(1) Encourages physicians to increase their awareness of the still largely overlooked problem of motor vehicle-related injuries and to discuss with their patients how they can avoid or prevent such injuries.
(2) Calls for the establishment of a reduction in motor vehicle injuries as a national goal.
(3) Reaffirms its support for the development of effective passive crash protection systems for occupants of motor vehicles.
(4) Strongly endorses and encourages the use of active restraints, such as lapbelts, lapbelt-shoulder harnesses, and those that are approved for children.
(5) Encourages motor vehicle manufacturers to develop automobiles with stronger passenger compartments that would more effectively protect occupants, and with interiors having fewer protuberant objects and hard surfaces that could cause injuries in crashes.
(6) Continues to support state and federal legislative efforts to strengthen drunk driving laws and their enforcement.
(7) Encourages national and federal organizations, such as the National Institutes of Health, the National Highway Transportation Safety Agency, and the National Science Foundation, and appropriate private groups, to devote more of their resources to research concerning vehicle-related injuries and their prevention.
(8) Urges states to review their standards for the construction and maintenance of roads and highways. The standards should be based on current engineering knowledge and good practice, particularly as related to use of skid-resistant surfaces; shoulder grading; drivers' lines of vision; removal of obstructions; and separation of opposing traffic streams.
(9) Encourages state and local officials to monitor streets, roads, and highways to identify sites with disproportionate risks of crashes, in order to take appropriate remedial actions.
(10) Encourages continued study of the effect of increasing the legal age at which young persons may drink alcoholic beverages and supports increased study of behavioral factors in crashes, such as those relating to education, training and driving experience; school, family and work problems; aggression; depression and personality disorders; use of drugs; and criminal behavior.
(11) Believes that, before the adoption of passive crash protection systems and devices to reduce motor vehicle injuries, industry and government demonstrate through field studies that such systems and devices are effective, safe, cost-effective and acceptable to drivers.
(12) Supports the use of legal and constitutional sobriety checkpoints to deter driving following alcohol consumption.

Child Passenger Safety H-15.993
Our AMA (1) urges all physicians and health care professionals to consider ways to encourage the protection of children in motor vehicles through the use of appropriate child passenger restraining devices
and safety belts and (2) endorses and supports the efforts of other appropriate organizations to motivate
and assist physicians and health care professionals and hospitals to inform parents of the importance of
protecting children in motor vehicles with appropriate restraining systems. (Res. 27, A-81; Reaffirmed:

Automobile Safety Standards H-15.999
The AMA supports proper legislation to establish safety standards for automobiles and will continue to
offer to government, industry, and other interested parties its advice and consultation on the medical
Report, I-98; Reaffirmed: BOT Rep. 23, A-09)
WHEREAS, The current annual lump sum each institution is allotted for a resident by Medicare is $112,000 in addition to a bonus for having Residents/Fellows at their institution; and

WHEREAS, A nurse practitioner in a Seattle ED can earn around $32 to $48 per hour while a Resident earns one-third of this payment for the same, if not more, tasks performed; and

WHEREAS, Residents are highly trained individuals, many of whom have accumulated debt from undergraduate degrees, Masters degrees, PhDs and medical school that, according to a study performed by Medscape, leaves 36% of Residents with more than $200,000 of debt for their education; and

WHEREAS, Resident salaries have essentially remained unchanged since 1974, with the mean inflation adjusted stipend in 1974 being $7,572 and in 2013-2014 being lower at $7,544; and

WHEREAS, Residents currently earn an average of $55,300/year although gross salaries divided into hourly pay are often less than $10 per hour depending on the resident work-week, which is often more than 80 hours a week; and

WHEREAS, Many residents have to relocate for their matched residencies, typically without being given compensation for relocation, and may endure large life milestones during residency such as marriage or having children; and

WHEREAS, The federal government is considering slashing programs that forgive Student Loan Debt in return for Public Service; and

WHEREAS, For the above reasons, the current residency payment models are not sustainable for trainees; therefore be it

RESOLVED, That our AMA work with appropriate stakeholders to create a guideline with indexed residency salaries to inflation taking into account cost of living and resident expenses, which hospitals and residency programs may use as a guideline to assist in determining residency salaries.

Fiscal Note:

References:


Relevant RFS & AMA Policy:

291.002R Evaluation of Resident and Fellow Compensation Levels: That our AMA: (1) develop recommendations for appropriate protections and increases to resident and fellow compensation and benefits with input from residents and fellows, and other involved parties including residency and fellowship programs; (2) advocate that resident and fellow trainees should not be financially responsible for their training; and (3) evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services, and address this in upcoming reports regarding graduate medical education financing. (Resolution 6, A-15)

Residents' Salaries H-305.930
Our AMA supports appropriate increases in resident salaries. (Res. 307, A-05; Reaffirmed: CME Rep. 1, A-15)

Determining Residents' Salaries H-310.922
Our AMA encourages teaching institutions to base residents' salaries on the resident's level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living. (Res. 303, A-06; Modified: CME Rep. 04, A-16)
AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 11
(I-17)

Introduced by: Gunjan Malhotra, MD; Luke Selby, MD MS; McKinley Glover IV, MD; Grayson Armstrong, MD MPH; Kathleen Doo, MD; Amar Kelkar, MD; Kelly Wong MD

Subject: Residency Match Systems and Timelines

Referred to: Reference Committee

Whereas, The residency match process and timeline for medical students varies slightly depending on the specialty; and

Whereas, Some residencies including urology and ophthalmology have an earlier match timeline and do not allow for couples matching; and

Whereas, There have been resolutions and CME reports regarding this issue and the RFS has no official position1,2; and

Whereas, Currently all specialties except urology and ophthalmology use the combination Electronic Residency Application Service (ERAS) and National Resident Matching Program (NRMP) match system “Main Residency Match”3,4; and

Whereas, Ophthalmology uses the combination Centralized Application Service (CAS) and San Francisco (SF) match system “Ophthalmology Residency Match Program” whereas urology still uses ERAS under the American Urological Association (AUA) match system “Urology Residency Matching Program”5,6; therefore be it

RESOLVED, That our AMA work with all invested stakeholders, specialties and application systems in the residency match excluding the military match to support and ensure parity with the match timeline and the ability to couples match by moving towards a unified and standardized process; and be it further

RESOLVED, That our AMA work with all invested stakeholders to design a provisional match system whereby medical students matching into preliminary (PGY-1) and, separately, advanced (PGY-2) residency programs match through a staggered system so that the PGY-2 match is timed with the match for all categorical PGY-1 positions and the match for preliminary PGY-1 programs is subsequently delayed to allow for a reduction in application and travel costs with the SOAP to follow the staggered match; and be it further

RESOLVED, That our AMA support and encourage all match application systems to provide robust match data to their applicants.

Fiscal Note:

References:
2. REPORT 6 OF THE COUNCIL ON MEDICAL EDUCATION (A-17): Standardizing the Allopathic Residency Match System and Timeline (Resolution 310-A-16) (Reference Committee C)


4. https://www.aamc.org/services/eras/

5. https://www.sfmatch.org/


Relevant RFS & AMA Policy:

260.003R NRMP All-In Policy: That our AMA does not support the current “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process. Also asked that the AMA work with the NRMP, and other external bodies (1) to revise match policy, including the secondary match or scramble process to create more standardized rules for all candidates and (2) to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants. (Report F, A-11)

Policy Suggestions to Improve the National Residency Match Program D-310.974

Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants; (4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while maintaining the integrity of the match and protecting the identities of both programs and participants; (5) advocate that the words “residency training” in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, “The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report” and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and (6) work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred. (CME Rep. 15, A-06; Appended: Res. 918, I-11; Appended: CME Rep. 12, A-12)

National Residency Match Program Reform D-310.977

Our AMA:

(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;

(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;

(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;

(4) will continue to review the NRMP’s policies and procedures and make recommendations for improvements as the need arises;

(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
(6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;

(7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;

(8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;

(9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;

(10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;

(11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;

(12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;

(13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;

(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;

(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;

(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA:

1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion.

2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process.

3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants. (Res. 307, A-09)
Resolution: 12  
(I-17)

Introduced by: Christopher Wee, MD; Laura Halpin, MD PhD; Michael Johnson, MD

Subject: Improving Utility of Clinical Documentation

Referred to: Reference Committee

Whereas, Regulatory guidelines associate reimbursement with the presence of certain quantities of components in documentation (e.g. review of systems, physical exam), even when not clinically relevant; and

Whereas, Providers are encouraged to document more components, which can lead to copying and pasting, leading to inaccuracies in documentation; and

Whereas, A survey of 1,515 trainees in twenty-four specialties showed that 92% of trainees felt that documentation obligations are excessive and that 73% of trainees felt documentation obligations has had a negative impact on patient care; and

Whereas, An observational study found physicians were most likely to first read the History, Physical, Assessment and Plan components of a clinical document, suggesting the non-utility of many components of current notes; and

Whereas, Reimbursement mechanisms are more likely to emphasize value over quantity of care in the future; and

Whereas, Existing AMA policy Medicare Guidelines for Evaluation and Management Codes H-70.952 states “inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required”; therefore be it

RESOLVED, That our AMA advocate that the appropriate regulatory institutions reduce the requirements for unnecessary, non-relevant components in clinical documentation; and be it further

RESOLVED, That our AMA advocate that the appropriate regulatory institutions determine level of care and reimbursement based more on complexity of medical diagnoses and medical decision making rather than quantity of components in medical documentation.

Fiscal Note:

References:


Relevant RFS & AMA Policy:

**291.026 Supervision of Residents**: That our AMA evaluate and advocate for the revision of the new HCFA rules concerning Medicare reimbursement for teaching physicians to ensure (1) more reasonable documentation requirements, (2) clarify and determine reasonable physical presence requirements, (3) expand the limited exception requirements for attending physician supervision to restore training for non-primary care residents at centers located in outpatient centers regardless of hospital affiliation. (Report F, A-97) (Reaffirmed Report D, I-16)

**Medicare Guidelines for Evaluation and Management Codes H-70.952**
Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services;

(2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse;

(3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians;

(4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS);

(5) will facilitate review and corrective action regarding the excessive content of the evaluation and management documentation guidelines in collaboration with the national medical specialty societies and to work to suspend implementation of all single system examination guidelines until approved by the national medical specialty societies affected by such guidelines,

(6) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS,

(7) urges CMS to establish a test period in a specific geographic region for these new guidelines to determine any effect their implementation will have on quality patient care, cost effectiveness and efficiency of delivery prior to enforcement of these mandated regulations;

(8) opposes adoption of the Medicare evaluation and management documentation guidelines for inclusion in the CPT; and

(9) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required. (Sub. Res. 801, I-97; Reaffirmation I-00; Reaffirmed: CMS Rep. 6, A-10)

**Insurers Excessive Documentation Requirements and Claims Submission D-70.991**
Our AMA will: (1) communicate with insurers that requires submission of medical record documentation for all Level 4 or Level 5 E & M codes that this practice is unacceptable and should be rescinded immediately; and (2) seek, if necessary, legal and governmental intervention to prevent any organization from requiring automatic and mandatory submission of medical record documentation for all CPT codes except unlisted procedures and codes with modifier-22. (Res. 827, A-00; Reaffirmed: CMS Rep. 6, A-10)

**Excessive Regulatory Costs H-155.974**
Our AMA will: (1) support actively seeking reduction in regulatory requirements such as record review, length-of-stay review, insurance requirements and form completion, and diagnosis coding for physicians and hospitals,
(2) vigorously oppose future regulatory requirements for physicians and hospitals that are not compensated;

(3) seek through appropriate legislative channels support for an Economic Impact Statement requirement for all legislation and regulation affecting the delivery of medical care and that the increased cost be reflected in the RBRVS value; and

(4) advocate that all governmental health care cost containment activities must simultaneously evaluate and report the total costs associated with their activities, and that government, federal, state and local, join the medical profession and hospitals in their efforts to contain the cost of health care, by reducing the number of regulations, reports, and forms. (Res. 125, A-79 Reaffirmed: CLRPD Rep. B, I-89; Res. 54, I-90; Res. 147, I-90; Res. 135, A-92; CMS Rep. 12, A-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 25, I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 7, A-11)
AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 13  
(I-17)

Introduced by: Nikesh Bajaj, MD

Subject: Acute Care of Patients with Dementia in Hospitals

Referred to: Reference Committee

Whereas, 13.9% of persons over the age of 71 have dementia and the elderly population in the United States is increasing; and

Whereas, One in four patients admitted to hospitals has dementia; and

Whereas, Patients with a diagnosis of dementia have worse outcomes during inpatient hospitalizations secondary to falls, pressure sores, poor nutrition, delirium et cetera, leading to decreased quality of life, longer hospital stays and increased costs of care; and

Whereas, Patients with dementia are more likely to be treated with inappropriate medications (antipsychotics, anticholinergics, opiates, polypharmacy) and/or over-diagnosed (asymptomatic bacteriuria as UTI) leading to unnecessary interventions (urinary catheterizations), all causing iatrogenic complications in care; and

Whereas, There is a need for guidelines and training for dementia care in the acute setting and research into how best to provide care for dementia patients in the acute setting; therefore be it

RESOLVED, That our AMA support research into determining how to best provide acute care for patients with dementia in the Hospital setting; and be it further

RESOLVED, That our AMA work with appropriate stakeholders to develop guidelines for the implementation in hospitals for acute care of patients with dementia.

Fiscal Note:

References:

Relevant RFS & AMA Policy:
340.008R Education on, Screening, and Reporting of Elder Abuse and Neglect: That our AMA-RFS promote elder abuse screening during patient encounters when deemed appropriate by the provider. (Resolution 4, A-17)

Long-Term Care Prescribing of Atypical Antipsychotic Medications H-25.989
Our AMA: (1) will collaborate with appropriate national medical specialty societies to create educational tools and programs to promote the broad and appropriate implementation of non-pharmacological techniques to manage behavioral and psychological symptoms of dementia in nursing home residents and the cautious use of medications; (2) supports efforts to provide additional research on other medications and non-drug alternatives to address behavioral problems and other issues with patients with dementia; and (3) opposes the proposed requirement that physicians who prescribe medications with "black box warnings on an off-label basis certify in writing that the drug meets the minimum criteria for coverage and reimbursement by virtue of being listed in at least one of the authorized drug compendia used by Medicare." (Res. 819, I-11)

Alzheimer's Disease H-25.991
Our AMA:

(1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias;

(2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;

(3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders;

(4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders;

(5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations;

(6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and

(7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease 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 disease and related dementias. (CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16)

Medication Administration in Assisted Living Facilities H-120.935
Our AMA supports medication administration by appropriately trained facility staff for residents of assisted living and dementia care facilities who require assistance in taking their medications. (CMS Rep. 9, A-15)

Physicians and Family Caregivers: Shared Responsibility H-210.980
Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;

(2) continues to support health policies that facilitate and encourage health care in the home;

(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;
(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and

(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients. (Res. 308, I-98; Reaffirmation A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17)
Resolution: 14

(Introduced by: Amar Kelkar, MD; Abeer Arain, MD, Iana Lesnikova, MD

Subject: Support for the Income-Driven Repayment Plans

Referred to: Reference Committee

Whereas, Since 2009 the U.S. Department of Education created several Income-Driven Repayment (IDR) plans that allow borrowers to select one of five plans for repaying their loans with base payment amounts based on the borrower’s income and repayment periods extended from the standard ten years to up-to twenty-five years with any remaining balance forgiven at the end of that period (these new loans went into effect for all new loans as of July 1, 2014); and

Whereas, The cost of these plans had not been adequately budgeted for by the Department of Education, leading to proposed budget cuts to programs including IDR plans and the Public Service Loan Forgiveness (PSLF) program; and

Whereas, Our AMA has made a concerted effort to reduce the burden of student loan debt, but has not specifically address IDR plans and their relevance to current and future medical students; therefore be it

RESOLVED, That our AMA collaborate with interested third party organizations to advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden.

Fiscal Note:

References:

Relevant RFS & AMA Policy:

281.006R Federal Student Loan Program Interest Rates: That our AMA: (1) analyze models of federal student loan and student loan consolidation program interest rate regulations (including fixed and variable
rates) and make recommendations to maximize their effectiveness in addressing medical education debt and patient access to health care; (2) utilize data from the study of federal loan and student loan consolidation program interest rate regulations to enhance its lobbying efforts toward the reauthorization of the Higher Education Act; and (3) provide a report to the AMA-HOD and RFS-HOD at A-05 regarding the reauthorization of the Higher Education Act at A-05; and (4) that our AMA-RFS forward this resolution immediately to the AMA at I-04. (Substitute Resolution 4, I-04) (Reaffirmed Report D, I-14) [Became HOD Resolution 729: Adopted I-04]

281.007R Student Loan Interest Rates: That our AMA actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 6.8%. (Amended Resolution 3, A-03) (Reaffirmed Report D, I-13) [HOD Resolution 316, A-03]

281.009R Deferment Period for U.S. Medical School Graduates’ Subsidized Federal Stafford Loans: That: (1) the RFS continue to support the ongoing efforts of the AMA to expand economic hardship deferment provisions for residents for the duration of their postgraduate training; and (2) our AMA develop legislation to expand economic hardship deferment provisions for resident physicians. (Substitute Resolution 1, A-01) (Reaffirmed Report D, I-16)

281.010R Maintaining Financial Solvency During Residency Training: Recommended that our AMA-RFS: (1) encourage resident physicians to work with hospitals and universities to examine the issue of student loan indebtedness and possible solutions including increased compensation packages; (2) continue to work with the AMA to encourage resident physicians to inform legislators of the impact of financing graduate medical education on career choice, specialty choice, and practice location; and (3) report to the Assembly on the results of the survey of medical students being conducted by the AMA Division of Undergraduate Medical Education. (Report N, I-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)

281.011R Student Loan Deferment: That: (1) the AMA-RFS work with the AMA-MSS and other interested parties to develop a grassroots campaign to educate federal legislators on the expanding burden of medical education debt in an effort to promote the need for extending deferment of student loans for post-graduate training; (2) that the AMA lobby the federal government for legislation that will achieve deferment of medical school loans for the entire residency and fellowship period. (Substitute Resolution 14, A-99) (Reaffirmed, Report C, I-09)

281.014R Deferral and Deduction of Student Loans: That our AMA-RFS initiate efforts to reinstate full deferral of medical student loans through the entire duration of training. (Substitute Resolution 15, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

281.019R Student Loan Deferment During Residency: That our AMA-RFS prepare a detailed report on AMA activities regarding medical student loan deferment during residency and make recommendations for further policy for consideration at the 1989 Interim Meeting. (RFS Substitute Resolution 24, A-89) In response to Substitute Resolution 24, the AMA-RFS adopted as amended Report D which reviewed the issue, AMA policy, and federal legislation, and asked that the: (1) AMA support efforts to grant forbearance to residents who request it without penalties, additional costs, or restrictions, but not to the exclusion of deferment; (2) AMA actively oppose legislative efforts to curtail or eliminate the classification of residents as students for purposes of loan deferment; and (3) AMA-RFS continue to inform resident physicians of any federal legislation pending on student loans and encourage residents to write their Congressmen and Senators. (Report D, I-89) (Reaffirmed Report C, I-99) [See also: AMA Policy H-305.965] (Reaffirmed Report D, I-16)


Student Loans H-305.965

Our AMA: (1) reaffirms its support of legislation that would defer the repayment of loans for education until the completion of residency training; and (2) will lobby for deferment of medical student loans for the
full initial residency period. (Sub. Res. 203, A-90; Appended Res. 306, I-99; Reaffirmation A-01; Reaffirmation I-06; Modified: CME Rep 01, A-16)

Proposed Revisions to AMA Policy on Medical Student Debt D-305.970
Our AMA will:

1. Collaborate, based on AMA policy, with members of the Federation and the medical education community, and with other interested organizations, to achieve the following immediate public- and private-sector advocacy goals:
   (a) Support expansion of and adequate funding for federal scholarship and loan repayment programs, such as those from the National Health Service Corps, the Indian Health Service, the Armed Forces, and the Department of Veterans Affairs, and for comparable programs at the state level.
   (b) Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
   (c) With each reauthorization of the Higher Education Act and at every other legislative opportunity, proactively pursue loan consolidation terms that favor students and ensure that loan deferment is available for the entire duration of residency and fellowship training.
   (d) Ensure that the Higher Education Act and other legislation allow interest from medical student loans to be fully tax deductible.
   (e) Encourage medical schools, with the support of the Federation, to engage in fundraising activities devoted to increasing the availability of scholarship support.
   (f) Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
   (g) Support stable funding for medical education programs to limit excessive tuition increases.

2. Encourage medical schools to study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, combined baccalaureate/MD programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education. (CME Rep. 13, A-06; Reaffirmation I-08)

Mechanisms to Reduce Medical Student Debt D-305.978
Our AMA will:
(1) take an active advocacy role during the upcoming reauthorization of the Higher Education Act and other pending legislation, to achieve the following goals: (a) eliminating the single holder rule, (b) making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training, (c) retaining the option of loan forbearance for residents ineligible for loan deferment, (d) including, explicitly, dependent care expenses in the definition of the "cost of attendance," (e) including room and board expenses in the definition of tax-exempt scholarship income, (f) continuing the loan consolidation program, including the ability to "lock in" a fixed interest rate, and (g) adding the ability to refinance Federal Consolidation Loans;
(2) continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases;
(3) encourage members of the Federation to develop or enhance financial aid opportunities for medical students;
(4) continue to monitor the availability of financial aid opportunities and financial planning/debt management counseling at medical schools, and share innovative approaches with the medical education community;
(5) continue to collect and disseminate information to assist members of the Federation (state medical societies and specialty societies) and medical schools to establish or expand financial aid programs; and
(6) continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students. (CME Rep. 10, A-04; Reaffirmation I-08)

Immediate Legislative Solutions to Medical Student Debt D-305.980
Our AMA will: (1) endorse and actively lobby for the Reauthorization of the Higher Education Act, including: (a) Elimination of the "single-holder" rule; (b) Continuation of the consolidation loan program
and a consolidator's ability to lock in a fixed interest rate; (c) Expansion of the deferment period for loan repayment to cover the entire duration of residency and fellowship; (d) Broadening of the definition of economic hardship as used to determine eligibility for student loan deferment; (e) Retention of the option of loan forbearance for residents who are ineligible for student loan deferment; and (f) Inclusion of dependent care expenses in the definition of "cost of attendance"; and

(2) lobby for passage of legislation that would: (a) Eliminate the cap on the student loan interest deduction; (b) Increase the income limits for taking the interest deduction; (c) Include room and board expenses in the definition of tax-exempt scholarship income; and (d) Make permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001. (Res. 850, I-03; Reaffirmation I-08)

Reduction in Student Loan Interest Rates D-305.984
1. Our AMA will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%.

2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the Graduate PLUS loan program.

3. Our AMA will consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates.

4. Our AMA will advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of high-borrowers paying higher interest rates and fees in addition to having a higher overall loan burden.

5. Our AMA will work with appropriate organizations, such as the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges, to collect data and report on student indebtedness that includes total loan costs at completion of graduate medical education training. (Res. 316, A-03; Reaffirmed: BOT Rep. 28, A-13; Appended: Res. 302, A-13; Modified and Appended: 301, A-16)

Medical School Financing, Tuition, and Student Debt D-305.993
1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of developing a web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection and loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes.

2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts.

3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.

5. Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians.
6. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians.

7. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.

8. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.

9. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.

10. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.

11. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility.

12. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.

13. Our AMA encourages medical school financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.

14. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes. (CME Rep. 2, I-00; Reaffirmation I-03; Reaffirmation I-06; Reaffirmation A-13; Appended: Res. 323, A-14; Appended: Res. 324, A-15; Appended: Res. 318, A-16; Appended: CME Rep. 07, A-17)
WHEREAS, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law designed to protect a subset of identifiable information known as Protected Health Information (PHI) and in 2009 HIPAA was expanded and strengthened by the Health Information Technology for Economic and Clinical Health Act (HITECH Act); and

WHEREAS, All technologies designed to be HIPAA-compliant must adhere to two rules: the 'Standards for Privacy of Individually Identifiable Health Information' known as the Privacy Rule, and the 'Security Standards for the Protection of Electronic Protected Health Information' known as the Security Rule; and

WHEREAS, Baseline cell phone security, text messaging and telecommunication technologies are lacking in necessary security measures to meet the standards for HIPAA-compliance; and

WHEREAS, There are an increasing number of HIPAA-compliant applications related to patient health and communication with several versions of developer's guides for HIPAA-compliance distributed online for several years; and

WHEREAS, Despite evidence from studies showing perceived improvement in provider communication with HIPAA-compliant text messaging applications, more than 50% of residents report routinely text messaging protected health information (PHI) in violation of HIPAA; therefore be it

RESOLVED, That our AMA advocate for the development and use of HIPAA-compliant technologies for text messaging, electronic mail and video conferencing; and be it further

RESOLVED, That our AMA develop a database of existing HIPAA-compliant technologies to be made accessible to the medical community.

Fiscal Note:

References:


Relevant RFS & AMA Policy:

**100.004R Ethical Physician Conduct in the Media:** That our AMA report on the professional ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication; that our AMA study disciplinary pathways for physicians who violate ethical responsibilities through their position on a media platform; that our AMA release a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media; and that this resolution be immediately forwarded to our AMA House of Delegates at A-15. (Resolution 21, A-15)

**Face-to-Face Encounter Rule D-330.914**

1. Our AMA will: (A) work with the Centers for Medicare & Medicaid Services (CMS) and appropriate national medical specialty societies to ensure that physicians understand the alternative means of compliance with and payment policies associated with Medicare's face-to-face encounter policies, including those required for home health, hospice and durable medical equipment; (B) work with CMS to continue to educate home health agencies on the face-to-face documentation required as part of the certification of eligibility for Medicare home health services to ensure that the certification process is streamlined and minimizes paperwork burdens for practicing physicians; and (C) continue to monitor legislative and regulatory proposals to modify Medicare's face-to-face encounter policies and work to prevent any new unfunded mandatory administrative paperwork burdens for practicing physicians.

2. Our AMA will work with CMS to enable the use of HIPAA-compliant telemedicine and video monitoring services to satisfy the face-to-face requirement in certifying eligibility for Medicare home health services. (CMS Rep. 3, I-12; Appended: Res. 120, A-14; Reaffirmed in lieu of: Res. 109, A-17)

**Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging D-478.970**

Our AMA: (1) will study the medicolegal implications of text messaging and other non-HIPAA-compliant electronic messaging between physicians, patients, and members of the health care team, with report back at the 2017 Annual Meeting; and 2) will develop patient-oriented educational materials about text messaging and other non-HIPAA-compliant electronic messaging communication between physicians, patients, and members of the health care team. (Res. 227, A-16)

**Guidelines for Patient-Physician Electronic Mail H-478.997**

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Furthermore, before using electronic mail or other electronic communication tools, physicians should consider Health Information Portability and Accountability Act (HIPAA) and other privacy requirements, as well as related AMA policy on privacy and confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

(a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.

(b) Inform patient about privacy issues.
(c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
(d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
(e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
(f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
(g) Request that patients put their name and patient identification number in the body of the message.
(h) Configure automatic reply to acknowledge receipt of messages.
(i) Send a new message to inform patient of completion of request.
(j) Request that patients use autoreply feature to acknowledge reading clinicians message.
(k) Develop archival and retrieval mechanisms.
(l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
(m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
(n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
(o) Explain to patients that their messages should be concise.
(p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
(q) Remind patients when they do not adhere to the guidelines.
(r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:
(a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
(b) Terms in communication guidelines (stated above).
(c) Provide instructions for when and how to convert to phone calls and office visits.
(d) Describe security mechanisms in place.
(e) Hold harmless the health care institution for information loss due to technical failures.
(f) Waive encryption requirement, if any, at patient's insistence.
(g) Describe security mechanisms in place including:
(h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
(i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
(j) Never using patient's e-mail address in a marketing scheme.
(k) Not sharing professional e-mail accounts with family members.
(l) Not using unencrypted wireless communications with patient-identifiable information.
(m) Double-checking all "To" fields prior to sending messages.
(n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
(o) Commit policy decisions to writing and electronic form.

(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.

(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.

(4) The policies and procedures for e-mail be applied to text and electronic messaging using a secure communication platform, where appropriate. (BOT Rep. 2, A-00; Modified: CMS Rep. 4, A-01; Modified: BOT Rep. 24, A-02; Reaffirmed: CMS Rep. 4, A-12; Modified: BOT Rep. 11, A-17)
Whereas, Planned Parenthood claims to be the largest provider of reproductive health services in the United States, offering sexual and reproductive health care in addition to education and outreach to nearly 5 million women, men and adolescents annually worldwide; and

Whereas, Planned Parenthood has 650 affiliate health centers across the nation, including stand-alone clinics and satellite offices with variation of services offered at different sites, servicing an estimated 2.5 million women and men with services and information each year in U.S. affiliated health centers and receiving an estimated 60 million visits annually to its website; and

Whereas, According to data from 2010 to 2012 nearly 80% of Planned Parenthood’s patients had incomes at or below 150% of the federal poverty level; and

Whereas, Planned Parenthood provides access to healthcare to those who would not otherwise have access to their specific healthcare services; and

Whereas, Previous AMA policy supports an increase in public and private health insurance coverage for women with low incomes to improve access to preventive women’s health care including pre-conception and inter-conception care; and

Whereas, In our current state of governmental affairs, public funding of women’s health services is becoming increasingly at-risk; and

Whereas, There is no AMA policy supporting the protection of government funding of all Women’s Health Services; therefore be it

RESOLVED, That our AMA support continued public funding of all full-spectrum women’s health services.

References:


Relevant RFS & AMA Policy:

294.016R Support for Women's Health: That our AMA-RFS support efforts to promote the multidisciplinary incorporation of women’s health education, research and training across all medical specialties and in medical school, residency training, and continuing medical education. (Substitute Resolution 11, I-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

390.001R Teenage Pregnancy Prevention: That our AMA provide testimony to Congress and actively support funding that provides reproductive preventative screenings and family planning services which are an essential part of women’s health services and vital for unintended pregnancy prevention. (Resolution 7, A-11)

390.008R Fair Access to Evidence-Based Family Planning Methods: That our AMA-RFS: (1) recognize that choices regarding family planning and medical or surgical termination of pregnancy are personal and autonomous and are to be made by a patient in concert with their health care provider; and (2) support changes to public and private payment mechanisms that would make evidence-based family planning methods and medical or surgical termination of pregnancy accessible to all patients, regardless of socioeconomic background. (Resolution 7, I-16)

390.009R Protection of Access and Coverage of Women’s Preventative and Maternity Care: That our AMA-RFS support legislation and regulations that ensure women have comprehensive coverage and access to preventative care, contraception, and maternity care with no cost sharing. (Late Resolution 1, A-17)

Public Funding of Abortion Services H-5.998
The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population. (Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 12, A-05; Reaffirmed: CMS Rep. 1, A-15)

Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission H-20.918
In view of the significance of the finding that treatment of HIV-infected pregnant women with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:

(1) Given the prevalence and distribution of HIV infection among women in the United States, the potential for effective early treatment of HIV infection in both women and their infants, and the significant reduction in perinatal HIV transmission with treatment of pregnant women with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all women. The ideal would be for all women to know their HIV status before considering pregnancy.

(2) Universal HIV testing of all pregnant women, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.

(3) The final decision about accepting HIV testing is the responsibility of the woman. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for the woman and her infant.

(4) To assure that the intended results are being achieved, the proportion of pregnant women who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of women accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.
(5) Women who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.

(6) When HIV infection is documented in a pregnant woman, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for her own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to her infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to herself and her infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for herself and her infant is the right and responsibility of the woman. When the woman's serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.

(7) Appropriate medical treatment for HIV-infected pregnant women should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the woman presents for prenatal or intrapartum care.

(8) To facilitate optimal medical care for women and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both mother and infant. Ideally, this information will be included in the confidential medical records. Physicians providing care for a woman or her infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the mother and infant, consistent with applicable state law.

(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for women presenting in labor and for women presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both women and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.

(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected women, should be maintained. (CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10)

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 pre-conception 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; Reaffirmed: CSAPH Rep. 01, A-17)
Subject: AMA-RFS Sunset Mechanism Procedure

Introduced by: RFS Governing Council

**Background**

In 1984, the House of Delegates established a sunset mechanism for House policies (G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to re-establish it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions, as well as to the efficiency and effectiveness of House deliberations.

This policy has been modified by the House on several occasions, the policy sunset process currently includes the following key steps:

- Each year, the House policies that are subject for review are identified and subsequently assigned to the appropriate AMA Councils for review.
- Each AMA Council that has been asked to review policies develops and submits a separate report to the House that presents recommendations on how the policies assigned to it should be handled.
- For each policy under review, the reviewing Council recommends one of the following alternatives: (a) retain the policy; (b) rescind the policy; (c) retain part of the policy or (d) reconcile the policy with more recent and like policy.
- For each recommendation, the Council provides a succinct justification for the recommendation.
- The Speakers assign the policy sunset reports for consideration by the appropriate reference committee.

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. The objective of the sunset mechanism is to help ensure that the AMA-RFS Digest of Actions is current, coherent, and relevant.

**Discussion**

Discussion regarding revision of the RFS sunset mechanism procedure began in 2016. At the 2017 RFS Annual Meeting, Resolution 5 titled “RFS Sunset Mechanism” was presented to the Assembly and referred to the Governing Council for study. Resolution 5 referenced AMA policy G-600.110 and the following resolve clauses:
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.

Due to the complexity of this issue, the Reference Committee recommended referral in hopes that the current process is explained and recommendations can be made to address confusion.

At the same 2017 RFS Annual Meeting, an informational report was released to the Assembly regarding a change in the sunset reports timing, which has been adjusted so that sunset reports will follow the 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. As a result, it is important to note that an Informational Sunset Report is currently published and was released for this meeting. Due to the language of 580.013 and the recommendations within this report being consistent with AMA policy G-600.110, the Informational Sunset Report was written in a manner consistent with the recommendations contained in this report.

If recommendations within this report are adopted, this will allow for the Assembly to move forward with the sunset report presented at the 2018 RFS Annual Meeting.

Current RFS Sunset Mechanism Procedure
The current RFS Sunset Mechanism procedure is outlined in the report, which precedes the report’s appendix. The appendix of the sunset report contains two lists of the policies up for review: 1) those recommended for reaffirmation and 2) those recommended for rescission. This
An informational report is presented at Interim prior to releasing the final report at the following meeting in order to allow sufficient time for delegates to: 1) review the initial recommendations and 2) have sufficient time to draft and submit new resolutions at the following Annual Meeting to compensate for well-intentioned policies that should be rescinded because they are outdated. Any new resolution must stand on its own, separate from the sunset report.

At the following Annual meeting, these lists are divided into two separate reports, each handled in the manner of a consent calendar. This consent calendar 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 “reaffirm” that item. Any delegate may move to reaffirm an action recommended for rescission, or vice-versa, at the Annual Meeting. However, in order for the sunset mechanism to operate efficiently and effectively, it is important that each delegate thoroughly review the Informational Sunset Report prior to the following meeting, taking into account the fact that they may want to draft new policy.

This current procedure accomplishes two important things: 1) review of RFS policy that builds in a system to ensure that any outdated policy that is rescinded is able to be replaced if an issue is viewed as important to the section and 2) ensures that the process for developing sound policy remains in-tact.

**New RFS Sunset Mechanism Procedure**

We believe that RFS policy 580.013R Sunset of AMA-RFS Policy which states:

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)

is sufficient to meet the needs of the RFS. While we understand the desire for procedure, a procedure currently exists and is reiterated in each informational and final sunset report. The RFS Digest of Actions is not the proper place to house procedure. A procedure differs from policy. Policy is codified and binds the section. Procedure is able to be adjusted to meet the needs of the section. We want to avoid a situation where we codify a procedure that is overly prescriptive and does not allow for adjustment based on the needs of the section. The timing of the sunset report is a good example of a procedural process that didn’t make sense based on the needs of the section and the timing of new leadership. Because this was a procedural issue, we were able to adjust the procedure based on the needs of the section while maintaining the intent of existing policy.

It’s important to address the fact that Resolution 5 resolve clauses 4, 5, and 7 exist in the current RFS sunset mechanism procedure. We believe these procedures should remain, but do not require a codified policy. While we can understand and appreciate the need to rescind a portion of existing policy that is no longer relevant. We believe that this particular ask does not have the effect of negatively impacting the process of developing sound policy. However, allowing amendments or “editorial” edits on the floor of extracted policies during the sunset procedure would be inefficient and put the section at risk of adopting policy that is not sound or
well thought out. Given the fact that efficiency and sound policy are basis for the sunset mechanism, this would not serve the section well.

We recommend that, for each policy under review, the sunset report should recommend to rescind, reaffirm, or rescind in-part will meet the needs of the section, along with a succinct justification for the recommendation. We believe this addresses the concerns of the Assembly, and allow the RFS to continue in the development of sound policy. Additionally, we believe that the only motions that should be in order is to “rescind”, “reaffirm”, and “rescind in-part”. A motion to “rescind in-part” will not allow for amendments on the floor; rather, it will be limited to the recommendation presented to the Assembly. If a delegate disagrees with the recommendation, that delegate will have sufficient time between reading the information sunset report which is presented to the Assembly and the final report to draft a new resolution. The new resolution must stand on its own independent of the sunset report. This process will allow for additional flexibility regarding the editing of existing policy without putting the policy-making process at-risk by allowing for edits on the floor of the Assembly.

Your Governing Council will work with appropriate standing committees, such as Committee on Long Range Planning, Committee on Medical Education, and Committee on Public Health, to receive committee feedback prior to publishing the informational report. We believe this will provide balance in the process, allow representatives additional time for review, provide valuable feedback, and allow committees to identify needs in policy and assign resolution topics to committee members if they see fit.

**Recommendation**

We recommend reaffirming policy 580.013R Sunset of AMA-RFS Policy and the remainder of this report be filed, which details the new sunset procedure that should be included in each sunset report.
AMA-RFS
RESOLUTIONS IN
HOUSE OF
DELEGATES
Memo to: AMA-RFS Assembly

From: Matthew Lecuyer, MD
AMA-RFS Chair

Date: November 2017

Subject: RFS HOD Items

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

Reference Committee B
- Res. 201 Improving FDA Expedited Approval Pathways

Reference Committee K
- Res. 901 Harmful Effects of Screen Time in Children
- Res. 952 Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training

Not for Consideration
- Financial Protections for Doctors in Training
Whereas, In the wake of the AIDS epidemic in the 1980s, the U.S. Food and Drug Administration (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 invalidated 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 American Medical Association work with U.S. Food and Drug Administration (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 (Directive to Take Action); 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.” (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 09/06/17

RELEVANT 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; Append: 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, Increased screen time amongst youth has been associated with an increase in morbidities such as obesity, sleep problems, depression and anxiety\(^1\); 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\(^2\); 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\(^2,3\); therefore be it

RESOLVED, That our American Medical Association encourage all schools to incorporate into health class curriculum the topic of balancing screen time with physical activity and sleep (New HOD Policy); 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 (New HOD Policy); 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. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 09/06/17

References:
\(^1\) https://www.ncbi.nlm.nih.gov/pubmed/28168778
\(^2\) http://www.health.harvard.edu/staying-healthy/blue-light-has-a-dark-side
\(^3\) http://journal.frontiersin.org/article/10.3389/fpubh.2015.00233/full

RELEVANT AMA POLICY
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)
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 American Medical Association: (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. (Directive to Take Action)
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.

5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

See also: Reducing Racial and Ethnic Disparities in Health Care D-350.995, Diversity in the Physician Workforce and Access to Care D-200.982

RELEVANT AMA POLICY

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.

5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

See also: Reducing Racial and Ethnic Disparities in Health Care D-350.995, Diversity in the Physician Workforce and Access to Care D-200.982

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