AMA Resident and Fellow Section

National Harbor, MD | Nov 8–10, 2018

Reports and Resolutions

American Medical Association - Resident and Fellow Section

I-18 Reports and Resolutions

Reference Committee Order of Business

Resolution 1	Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use
Resolution 2	Support for Medicare Disability Coverage of Contraception for Women of Reproductive Age
Resolution 3	Increasing Rural Rotations During Residency
Resolution 4	Promoting Nutrition Education Among Healthcare Providers
Resolution 5	DACA in GME
Resolution 6	Contraception for Incarcerated Women
Resolution 7	Decreasing Financial Burdens on Residents and Fellows
Resolution 8	Strategies to Reduce Burnout on Medical Trainees
Resolution 9	Medical Aid in Dying
Resolution 10	Improving Patient Care through Patient Self Awareness of Personal Health Information
Resolution 11	Delegation of Informed Consent

AMA-RFS Resolutions in House of Delegates

Reference Committee K	
911	Regulating Tattoo and Permanent Makeup Inks
953	Support for the Income-Driven Repayment Plans
951	Prevention of Physician and Medical Student Suicide
912	Comprehensive Breast Cancer Treatment
Reference Committee B	
203	Support for the Development and Distribution of HIPAA-Compliant Communication Technologies
204	Restriction on IMG Moonlighting
Reference Committee J	
803	Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogram

Informational Reports

Report A	Organizational Report
Report B	Advocacy Issues Update
Report C	Fiscal Affairs
Report D	IOP Ad-Hoc Committee Update

REFERENCE COMMITTEE BUSINESS

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1
(I-18)

Introduced by: VERONICA M. ALVAREZ-GALIANA, MD, MSED

Subject: SUPPORT FOR MEDICARE DISABILITY COVERAGE OF CONTRACEPTION FOR NON-CONTRACEPTIVE USE

Referred to: Reference Committee

Whereas, There are several non-contraceptive uses of hormonal contraception including treatment of abnormal uterine bleeding and endometrial hyperplasia; and

Whereas, Patients on Medicare disability insurance who present with abnormal uterine bleeding and/or endometrial hyperplasia may be poor surgical candidates thus limiting options to medical treatment with hormonal methods that may include contraceptive pills or long-term reversible contraception including the levonorgestrel intrauterine device; and

Whereas, Patients who are on Medicare disability insurance do not have coverage for contraception, including the levonorgestrel intrauterine device; therefore be it

RESOLVED, That our AMA-RFS encourage CMS to include coverage for all FDA-approved contraception, including the levonorgestrel intrauterine device, for non-contraceptive use in patients covered by Medicare disability insurance.

Fiscal Note:

References:

1. ACOG Committee on Practice Bulletins – Gynecology (2010, reaffirmed 2018). “ACOG Practice Bulletin No. 110: Noncontraceptive Uses of Hormonal Contraceptives”. Obstetrics and Gynecology 115(1): 206-218.

2. AAFP News (2017). “AAFP Addresses Contraceptive Access and Coverage With FDA, CMS”. American Family Physician. Retrieved June 23 from www.aafp.org/news/health-of-the-public/20170821contraceptivesletter.html.

3. Kaiser Family Foundation (2015). “Private and Public Coverage of Contraceptive Services and Supplies in the United States”. Retrieved June 23 from https://www.kff.org/womens-health-policy/fact-sheet/private-and-public-coverage-of-contraceptive-services-and-supplies-in-the-united-states/#footnote-157263-16

4. Mosher, W., Bloom, T., Hughes, R., Horton, L., Mojtabai, R., & Alhusen, J. L. (2017). “Disparities in receipt of family planning services by disability status: New estimates from the National Survey of Family Growth”. Disability and Health Journal 10(3): 394-399. doi:10.1016/j.dhjo.2017.03.014

5. Pharr, J. R., & Bungum, T. (2012). “Health Disparities Experienced by People with Disabilities in the United States: A Behavioral Risk Factor Surveillance System Study”. Global Journal of Health Science 4(6):99-108. doi:10.5539/gjhs.v4n6p99

Relevant RFS & AMA Policy:

390.009R Protection of Access and Coverage of Women's Preventative and Maternity Care: That our AMA - RFS support legislation and regulations that ensures women have comprehensive coverage and access to preventative care, contraception, and maternity care with no cost sharing. (Late Resolution 1, A - 17) (Reaffirmed Resolution 16, I - 17)

H-180.958 Coverage of contraceptives by Insurance
1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.

2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 2
(I-18)

Introduced by: VERONICA M. ALVAREZ-GALIANA, MD, MSED

Subject: SUPPORT FOR MEDICARE DISABILITY COVERAGE OF CONTRACEPTION FOR WOMEN OF REPRODUCTIVE AGE

Referred to: Reference Committee

Whereas, Women of reproductive age who have disabilities may be at risk for unintended pregnancy; and

Whereas, Women of reproductive age who have disabilities may have higher risk pregnancies should they become pregnant; and

Whereas, Women with disabilities who become pregnant have Medicaid coverage for pregnancy but cannot obtain coverage for contraception after the pregnancy, including bilateral tubal ligation; and

Whereas, Women of very low income with Medicare disability may apply for Medicaid dual coverage however this may create a time delay for women seeking contraception; and

Whereas, Women with Medicare disability insurance who do not meet the eligibility criteria for Medicaid do not have access to contraception; therefore, be it

RESOLVED, That our AMA-RFS encourage CMS to provide coverage for all FDA-approved contraception for reproductive aged women covered by Medicare disability insurance.

Fiscal Note:

References:

1. ACOG Committee on Health Care for Underserved Women (2015, reaffirmed 2017). “ACOG Committee Opinion No. 615: Access to Contraception”. Obstetrics and Gynecology 125: 250-255.

2. AAFP News (2017). “AAFP Addresses Contraceptive Access and Coverage With FDA, CMS”. American Family Physician. Retrieved June 23 from www.aafp.org/news/health-of-the-public/20170821contraceptivesletter.html.

3. Kaiser Family Foundation (2015). “Private and Public Coverage of Contraceptive Services and Supplies in the United States”. Retrieved June 23 from https://www.kff.org/womens-health-policy/fact-sheet/private-and-public-coverage-of-contraceptive-services-and-supplies-in-the-united-states/#footnote-157263-16

4. Mosher, W., Bloom, T., Hughes, R., Horton, L., Mojtabai, R., & Alhusen, J. L. (2017). “Disparities in receipt of family planning services by disability status: New estimates from the National Survey of Family Growth”. Disability and Health Journal 10(3): 394-399. doi:10.1016/j.dhjo.2017.03.014

5. Pharr, J. R., & Bungum, T. (2012). “Health Disparities Experienced by People with Disabilities in the United States: A Behavioral Risk Factor Surveillance System Study”. Global Journal of Health Science 4(6):99-108. doi:10.5539/gjhs.v4n6p99

Relevant RFS & AMA Policy:

390.009R Protection of Access and Coverage of Women’s Preventative and Maternity Care: That our AMA - RFS support legislation and regulations that ensures women have comprehensive coverage and access to preventative care, contraception, and maternity care with no cost sharing. (Late Resolution 1, A - 17) (Reaffirmed Resolution 16, I - 17)

H-180.958 Coverage of contraceptives by Insurance
1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.
2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care. [Res. 221, A-98 Reaffirmation A-04 Reaffirmed: CMS Rep. 1, A-14 Reaffirmation: I-17 Modified: BOT Rep. 10, A-18]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 3
(I-18)

Introduced by: LUKE V. SELBY, MD, MS; RAGHU PUTTAGUNTA, MD

Subject: INCREASING RURAL ROTATIONS DURING RESIDENCY

Referred to: Reference Committee

Whereas, Residents of rural areas are generally older and sicker than their urban counterparts; and

Whereas, Rural areas are facing a crisis due to physician shortages; and

Whereas, Residents and fellows are more likely to practice where they train; and

Whereas, Many residency programs offer elective rotations where residents can pursue areas of interest not offered in their main residency curriculum; and

Whereas, The documentation requirements for faculty supervising residents can be substantial; therefore be it

RESOLVED, That our AMA work with state and specialty societies, medical schools, teaching hospitals, ACGME, CMS and other interested stakeholders to encourage and incentive qualified rural physicians to serve as preceptors, volunteer faculty, etc. for rural rotations in residency; and be it further

RESOLVED, That our AMA work with ACGME, ABMS, FSMB, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas; and be it further resolved

RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase residency training opportunities with a report back to the HOD and formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

Fiscal Note:

References:

Relevant RFS & AMA Policy:
130.010R Rural Health Care Initiative:
That our AMA-RFS support financial incentives, such as federal tax incentives, to both rural health care providers and rural health care institutions serving patient populations that fall outside a 60-mile radius of urban areas with a population of 50,000 or greater. (Substitute Resolution 16, A-95) [See also: AMA Policy H-465.994, H-465.997] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage

In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.
(2) Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.
(3) Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.
(4) Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.
(5) Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.
(6) Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.
(7) Our AMA support full funding of the new federal National Health Service Corps loan repayment program.
(8) Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.
(9) Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.
(10) Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.
(11) Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.
(12) Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners. [CME Rep. C, I-90 Reaffirmation A-00 Reaffirmation A-01 Reaffirmation I-01 Reaffirmed: CME Rep. 1, I-08 Reaffirmed: CEJA Rep. 06, A-18]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 4
(I-18)

Introduced by: ABEER ARAIN, MD, MPH

Subject: PROMOTING NUTRITION EDUCATION AMONG HEALTHCARE PROVIDERS

Referred to: Reference Committee

Whereas, The prevalence of obesity in the United States is on the continuous rise unchecked, with more than one-third of the population being obese; and

Whereas, The growing burden of obesity is enormous, with about $68 billion direct medical costs and 280,000 deaths each year.;[1] and

Whereas, Millions of people in the US file for disability each year;[2] and

Whereas, Clinicians tend to focus more on the complications of obesity such as hypertension, Type II Diabetes and coronary artery disease. However, the importance of primary prevention in early identification and intervention of obesity is seldom discussed by physicians; and

Whereas, The common misconception that nutrition counseling is not their role, but rather the function of dieticians, is still prevalent among healthcare providers; and

Whereas, Some of the important barriers to counseling include lack of nutrition knowledge and skills in nutrition counseling among the medical practitioners.[3] Physicians often do not feel comfortable, confident, or adequately prepared in discussing their patients' diet;[3] and

Whereas, Targeting the dietary habits of our patients and preventing obesity offers a tremendous opportunity to optimize the overall quality of patient care, improve clinical outcomes, and reduce overall healthcare costs; and

Whereas, Nutrition knowledge appears confined largely to books and exams. In fact, according to one study, doctors engage in nutrition counseling with patients only 11% of the time;[3] and

Whereas, In teaching hospitals, where residents work closely with patients, it is crucial that residents develop a comprehensive knowledge of nutrition science and apply that knowledge to clinical practice; therefore be it

RESOLVED, That our AMA will advocate for recognizing the importance of a better foundation of an evidence based-approach to nutrition for the prevention and management of chronic diseases; and be it further

RESOLVED, That our AMA will work in collaboration with educational institutions and residency programs to advocate for nutrition knowledge among physicians-in-training to promote healthy eating habits among our patients; and be it further

RESOLVED, That our AMA will promote a strong foundation of nutrition concepts and techniques of motivational interviewing that will foster the importance of educating patients regarding lifestyle changes.

Fiscal Note:

References:

1. Tremmel M, Gerdtham U-G, Nilsson PM, Saha S. Economic burden of obesity: A systemic literature review. Int J Environ Res Public Health.2017; 14(4):435.
2. Lazarus K, Weinsier RL, Boker JR. Nutrition knowledge and practices of physicians in a family-practice residency program: the effect of an education program provided by a physician nutrition specialist. Am J Clin Nutr.1993; 58:319-25.
3. Vetter ML, Herring SJ, Sood M, Shah NR, Kalet AL. What do resident physicians know about nutrition? An evaluation of attitudes, self-perceived proficiency and knowledge. J Am Coll Nutr.2008; 27(2):287-298.

Relevant RFS & AMA Policy:
410.008R Exercise and Healthy Eating for Children:
That our AMA: (1) support legislation that would require the development and implementation of universal nutrition standards for all food served in K-12 schools irrespective of food vendor or provider and (2) spearhead a public health awareness campaign and enhance the K-12 curriculum to address and educate the public on the epidemic of childhood obesity and the benefits of exercise and physical fitness for children. (Substitute Resolution 6, A-02) (Reaffirmed Report D, I-12) [See also: HOD Resolution 423, A-02]

H-150.996 Nutrition Education
Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools. [Sub. Res. 66, I-77 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CME Rep. 2, A-10 Modified: CME Rep. 01, A-17]

H-425.972 Healthy Lifestyles
1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (B) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.
2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education. [Res. 423, A-12 Appended: Res. 959, I-17]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 5
(I-18)

Introduced by: TANI MALHOTRA, MD, KATHLEEN DOO, MD, IVA GOLEMI, MD, ARJUN GUPTA, MD, ASGHAR HAIDER, MD, IANA LESNIKOVA, MD, LAURA STONE McGUIRE, MD, JARNA SHAH, MD, HEYWAN TESFAYE, MD

Subject: DACA IN GME

Referred to: Reference Committee

Whereas, There is an anticipated shortage of over 100,000 doctors by the year 2030, especially in primary care; and

Whereas, A recent study in the Journal of Graduate Medical education found that "there are simply not enough US-trained physicians to fill all the available residency and fellowship positions" in primary care specialties;[6] and

Whereas, A 2018 study by the American Medical Association on non-US IMGs found that 64% are working in primary care, and 66% of non-US IMGs that matched in 2018 did so in primary care fields; and

Whereas, In 2014-2015, there were 1,879 physicians from Muslim-majority countries including many on the travel ban list, practicing on a J-1 visa, a visa obtained during residency training that upon completion of training, requires holders to find "J-1 waiver" jobs which recruit physicians into underserved areas;"[3] and

Whereas, A New York Times article described "changes in visa policies prevent foreign graduate (IMG) doctors from practicing and increase medical provider shortages especially in rural communities;"[2] and

Whereas, 2018 saw the lowest number of non-US IMG applicants since 2005;[16] and

Whereas, an open-letter by ACGME described the "profound moral distress [a travel ban] has provoked within the health care community;"[1] and

Whereas, ECFMG Statement to Supreme Court (2018) "In the United States, where one-quarter of our physicians have received their medical degree outside the United States and Canada, the ability to provide accessible, high-quality health care depends on our ability to continue to attract highly qualified physicians from around the world. Anything that disrupts the flow of these talented and qualified professionals into the United States will have a negative and potentially long-term impact on patient care. We urge immigration policymakers to consider the many contributions that foreign national physicians make to our healthcare system and our economy, and to ensure that United States remains an attractive option for the best and brightest minds from around the world";[4] and

Whereas, New data shows that in 2017, U.S. Citizenship and Immigration Services denied more H-1B petitions, preventing more foreign nationals from working in America,[12] and there is concern that these rejections will affect medical residents in training in the U.S;[13] and

Whereas, Multiple US medical organizations including the Accreditation Council for Graduate Medical Education (ACGME), the Association of American Medical Colleges, Alliance for Academic Internal Medicine, American Academy of Family Medicine, American Academy of Pediatrics, and the American College of Physicians have expressed concern over executive orders limiting immigration and their impact on graduate medical education; [1, 6-11] therefore be it

RESOLVED, That D-255.991 be reaffirmed; and be it further

RESOLVED, That our AMA advocate against the use of visa status, immigration status, or nationality for admission criteria when evaluating graduate medical education applicants; and be it further

RESOLVED, That our AMA support Deferred Action for Childhood Arrivals recipients such that they need not face potential legal challenges; and be it further

RESOLVED, That our AMA urge policy makers to continue the program so that the candidates may complete their medical school, residency, and fellowship training; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA-HOD.

Fiscal Note:

References:

1. Accreditation Council for Graduate Medical Education. Nasca immigration letter. February 2, 2017. https://www.acgme.org/Portals/0/PDFs/Nasca-Community/Nasca-Letter-Immigration-2-2-17.pdf. Accessed August 19/2018.
2. Rural Areas Brace for a Shortage of Doctors Due to Visa Policy. March 18,2017. https://www.nytimes.com/2017/03/18/us/doctor-shortage-visa-policy.html
3. Masri, A and Senussi, M. Trump's Executive Order on Immigration — Detrimental Effects on Medical Training and Health Care. New England Journal of Medicine. 2017(376):e39. Accessed August 21, 2018.
4. ECFMG Statement on Supreme Court Decision to Uphold Visa Restrictions in Presidential Proclamation. June 26, 2018; https://www.ecfmg.org/news/2018/06/26/ecfmg-statement-on-supreme-court-decision-to-uphold-visa-restrictions-in-presidential-proclamation/
5. Poll-Hunter, Norma I. et al. Values Guide Us in Times of Uncertainty: DACA and Graduate Medical Education. Academic Medicine Nov 2017.
6. Reem A. Mustafa, Fadi Bdair, M. Hassan Murad, and David Wooldridge (2017) Immigration, Graduate Medical Education, and Ethical Dilemmas. Journal of Graduate Medical Education: June 2017, Vol. 9, No. 3, pp. 280-282.
7. Association of American Medical Colleges. AAMC statement on President Trump's executive order on immigration. January 30, 2017. https://news.aamc.org/press-releases/article/executive-order-immigration-013017. Accessed April 24, 2017. [Google Scholar]
8. Alliance for Academic Internal Medicine. AAIM statement on the executive order on immigration. February 2, 2017. http://www.im.org/p/cm/ld/fid=1653. Accessed August 24, 2018.
9. American Academy of Family Physicians. ABFM statement regarding executive order travel ban. February 2, 2017. https://www.theabfm.org/about/travelban2017.pdf. Accessed August 24, 2018
10. Stein F. AAP statement on revised immigrant and refugee travel ban executive order. American Academy of Pediatrics. March 6, 2017. https://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Statement-on-Revised-Immigrant-and-Refugee-Travel-Ban-Executive-Order.aspx. Accessed August 24, 2018
11. Damle NS. American College of Physicians issues comprehensive statement on US immigration

policy. January 31, 2017. https://www.acponline.org/acp-newsroom/acp-comprehensive-statement-us-immigration-policy. August 24, 2018
12. Anderson S. New evidence USCIS policies increased denials of H-1B visas." https://www.forbes.com/sites/stuartanderson/2018/07/25/new-evidence-uscis-policies-increased-denials-of-h-1b-visas/#24c56ac85a9f. September 2, 2018
13. Ducharme J. Trump's immigration policies are making it harder for foreign doctors to work in the U.S. - and that could hurt patients. http://time.com/5299488/international-medical-graduates/. September 2, 2018
14. http://www.nrmp.org/wp-content/uploads/2018/06/Charting-Outcomes-in-the-Match-2018-IMGs.pdf
15. (https://news.aamc.org/press-releases/article/workforce_report_shortage_04112018/)
16. http://www.nrmp.org/wp-content/uploads/2018/04/Main-Match-Result-and-Data-2 018.pdf

Relevant RFS & AMA Policy:

H-255.988 AMA Principles on International Medical Graduates
Our AMA supports:
1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.

14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state

boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state. [BOT Rep. Z, A-86; Reaffirmed: Res. 312, I-93; Modified: CME Rep. 2, A-03; Reaffirmation I-11; Reaffirmed: CME Rep. 1, I-13; Modified: BOT Rep. 25, A-15; Modified: CME Rep. 01, A-16; Appended: Res. 304, A-17; Modified: CME Rep. 01, I-17]

D-350.986 Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages
1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients. [Res. 305, A-15; Appended: Late Res. 1001, I-16]

D-200.985 Strategies for Enhancing Diversity in the Physician Workforce
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 develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. 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.
7. 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.
8. 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.
9. 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.
10. 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).
11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities. [CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18]

D-255.980 Impact of Immigration Barriers on the Nation's Health
1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S. [Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18]

D-255.991 Visa Complications for IMGs in GME
1. Our AMA will: (A) work with the ECFMG to minimize delays in the visa process for International Medical Graduates applying for visas to enter the US for postgraduate medical training and/or medical practice; (B) promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for International Medical Graduates; and (C) work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants to reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position.
2. Our AMA International Medical Graduates Section will continue to monitor any H-1B visa denials as they relate to IMGs? inability to complete accredited GME programs.
3. Our AMA will study, in collaboration with the Educational Commission on Foreign Medical Graduates and the Accreditation Council for Graduate Medical Education, the frequency of such J-1 Visa reentry denials and its impact on patient care and residency training.
4. Our AMA will, in collaboration with other stakeholders, advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care. [Res. 844, I-03; Reaffirmation A-09; Reaffirmation I-10; Appended: CME Rep. 10, A-11; Appended: Res. 323, A-12]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 6
(I-18)

Introduced by: CAITLIN FARRELL, DO, MPH, CHRISTIANA SHOUSHTARI, MD, MPH

Subject: CONTRACEPTION FOR INCARCERATED WOMEN

Referred to: Reference Committee

Whereas, The United States accounts for over 30% of the world's population of incarcerated women[1] and currently houses more than 200,000 female prisoners[2]; and

Whereas, The population of females in jail or prison worldwide has risen 53% since the year 2003; and

Whereas, The majority of incarcerated women in the United States are between the ages of 18 and 44, and therefore are within reproductive age4; and

Whereas, Up to 84% of incarcerated women have had a prior unintended pregnancy5, 77-84% of incarcerated women plan to be sexually active within six months of release6 and 72% of incarcerated women were not using a regular form of contraception prior to incarceration; and

Whereas, The majority of women incarcerated have multiple barriers to accessing healthcare upon release from jail, and incarceration provides a unique opportunity to provide healthcare to a resource poor population; and

Whereas, Our AMA has policy which advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females and encourages improved access to comprehensive physical and behavioral health care services to adults and juveniles while incarcerated; and

Whereas, Our AMA has policy that advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum; therefore be it

RESOLVED, That our AMA advocates for state and local health departments to work with correctional facilities to provide contraception to incarcerated women prior to release; and be it further

RESOLVED, That our AMA encourage partnerships between healthcare providers and correctional care communities, including state and local health departments, correctional facilities and community healthcare centers, so that access to contraception among women recently released from correctional facilities may be increased; and be it further

RESOLVED, That our AMA recognize that access to contraception is a serious healthcare concern among incarcerated women; and be it further

RESOLVED, That our AMA petition the National Commission on Correctional Healthcare to recognize that access to contraception is a serious healthcare concern among incarcerated

women.

Fiscal note:

References:

1. Kajstura, Alexis. (2018), “States of Women’s Incarceration: The Global Context 2018” Prison Policy Initiative. URL https://www.prisonpolicy.org/global/women/2018.html, accessed August 31, 2018.
2. Walmsley, R (2017). World Female Imprisonment List, Fourth Edition. Institute for Criminal Policy Research.
3. Kajstura, Alexis (2017), “Women’s Mass Incarceration: The Whole Pie 2017”. Prison Policy Initiative. URL https://www.prisonpolicy.org/reports/pie2017women.html Accessed August 31, 2018.
4. Carson, AE (2018), “Prisoners in 2016” (No. NCJ 251149), Department of Justice, Bureau of Justice Statistics, Washington DC.
5. Clarke, JG; Hebert, MR; Rosengard, C; et al. “Reproductive healthcare and family planning needs among incarcerated women”, Am Journal Public Health, Vol 96, p. 834-839.
6. Larocelle, F; Castro, C; Goldenson, J; Tulsky, JP; et al. (2012), “Contraceptive use and barriers to access among newly arrested women”, J Correct Health Care, Vol 18, p. 111-119.
7. Oswalt, K; Hale, GJ; Cropsey, KL; et al. (2010), “The contraceptive needs for STD protection among women in jail”, Health Educ. Behav. Off. Publ. Soc. Health Educ., Vol 37, p. 568-579.

Relevant RFS & AMA Policy:

H-430.986 Health Care While Incarcerated
1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.

3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.

5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.

6. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.

7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women. [CMS Rep. 02, I-16]

H-430.997 Standards of Care for Inmates of Correctional Facilities

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism. [Res. 60, A-84 Reaffirmed by CLRPD Rep. 3 - I-94 Amended: Res. 416, I-99 Reaffirmed: CEJA Rep. 8, A-09 Reaffirmation I-09 Modified in lieu of Res. 502, A-12 Reaffirmation: I-12]

H-75.987 Reducing Unintended Pregnancy
Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long- acting reversible contraceptives as efficacious and economical forms of contraception. [Res. 512, A-97 Reaffirmed: CSAPH Rep. 3, A-07 Reaffirmation A-15 Appended: Res. 502, A-15 Reaffirmation I-16]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 7
(I-18)

Introduced by: TANI MALHOTRA, MD; LUKE SELBY, MD, MS

Subject: DECREASING FINANCIAL BURDENS ON RESIDENTS AND FELLOWS

Referred to: Reference Committee

Whereas, The average resident salary in 2015 was $55,400 with a range of $52,000 - $66,000 depending on the years of post-graduate training[1]; and

Whereas, Sixty six percent of residents surveyed in 2015 reported receiving a meal allowance and less than three percent reported receiving a day care allowance[1]; and

Whereas, The Accreditation Council for Graduate Medical Education (ACGME) requires institutions to make food accessible to residents and fellows on call but makes no mention of the cost of the food[2]; and

Whereas, A majority of residents and fellows are in their reproductive ages and in 2016 women make up 45.8% of all residents and fellows[3]; and

Whereas, Residents and fellows are required at the hospital at all hours of the day and may pay up to $200/month in parking fees to the institution and only 53% of institutions report covering the cost of parking[4]; and

Whereas, A majority of residents, regardless of the years of training spend greater than 60 hours per week at the hospital and 43% take more than five night calls per month[1]; and

Whereas, Thirty-seven percent of residents and fellows have over $200,000 in medical school debt[1]; and

Whereas, A study published in JAMA found that increased education debt among internal medicine residents was associated with increased burnout and lower scores on in-training exams[5]; and

Whereas, AMA policy H305.988 “supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians” and salary deductions for parking, meals on call, and finding reliable child care contribute to increased financial strain on residents and fellows; and

Whereas, Median salaries reported by residencies have demonstrated appropriate increases over the years, however this does not take in to consideration the salary deductions made for parking, meals on call, and child care which contribute to lower net salaries and increased financial strain[4]; therefore be it

RESOLVED, That our AMA partner with the ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing

subsidized access to day care facilities and other basic necessities such as on call meal allowances for residents taking in-house call, and free parking on site, and further be it

RESOLVED, That this resolution be forwarded to AMA-HOD at A-19.

Fiscal Note:

References:

1. https://www.medscape.com/slideshow/2018-residents-salary-debt-report-6010044
2. https://www.acgme.org/Portals/0/PFAssets/InstitutionalRequirements/000InstitutionalRequirements2018.pdf?ver=2018-02-19-132236-600
3. https://www.aamc.org/data/484710/report-on-residents.html
4. https://www.aamc.org/download/471828/data/2016stipendsurveyreportfinal.pdf
5. West, CP, Shanafelt, TD, Kolars, JC. Quality of Life, Burnout, Educational Debt, and Medical Knowledge Among Internal Medicine Residents. *JAMA.* 2011;306(9):952-960

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)

291.011R Provision of Child Care by Residency and Fellowship Training Programs: That our AMA (1) begin collecting more comprehensive data on the provision of child care services or stipends for child care by residency and fellowship programs using the Freida database and (2) evaluate the progress made in the provision of child care and different models being utilized by training programs. (Resolution 4, A-08)

291.015R Intern and Resident Burnout: That our AMA-RFS work with the ACGME to study resident burnout and determine if (1) recommendations can be made on how to recognize burnout, how to treat it, and, if possible, how to prevent it; (2) it relates to the professionalism core competency for residents; and (3) recognizing, treating and possibly preventing burnout could be included in the program requirements for residency program directors. (Resolution 3, A-06) (Reaffirmed Report D, I-16)

295.004R Minimum Resident Benefits: That our AMA-RFS continue to monitor the revision of the "General Requirements" of the Essentials of Accredited Residencies in Graduate Medical Education for significant changes in benefits language, and act on them as appropriate within current AMA-RFS actions and AMA policies. (Report I, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09)

H-310.912 Residents and Fellows' Bill of Rights

H-305.988 Cost and Financing of Medical Education and Availability of First-Year Residency Positions
Our AMA:
1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;

4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

H-310.922 Determining Residents' Salaries
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.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 8
(I-18)

Introduced by: EBELE COMPEAN, MD, STEPHANIE LEE MD, FAAP, BEN BERTEAU, MD, JUSTIN ELLIOTT KATZ, MD, MBA, MS

Subject: STRATEGIES TO REDUCE BURNOUT IN MEDICAL TRAINEES

Referred to: Reference Committee

Whereas, Burnout is a condition characterized by diminished sense of personal accomplishments, detachment, cynicism, emotional fatigue and depersonalization;[1,2] and

Whereas, A Mayo study found that in 2011, 46% of physicians had at least one symptom of burnout; however, this increased to 54% 3 years later; [1,2] and

Whereas, Physician suicide is astronomically higher than the general population with female doctors more disproportionately affected than male doctors; [3,4] and

Whereas, There is evidence that organizational strategies are more effective in reducing burnout than physician-directed interventions; [2,5-7] and

Whereas, In addition to being physicians, residents and fellows are still trainees with didactics and educational times that need to be fully protected, as this has shown to improve learning, although there is a need for further research on whether this will relieve burnout; [8,9] and

Whereas, Our AMA-RFS has existing policy which encourages further studies on recognizing, preventing and handling of burnout in residents (291.015R (Resolution 3, A-06; Reaffirmed Report D, I-16); therefore be it

RESOLVED, That our AMA-RFS support taking quantitative, definitive steps towards studying and implementing organizational level strategies to decrease medical trainee burnout; and be it further

RESOLVED, That our AMA-RFS amend internal policy “Intern and Resident Burnout” 291.015R by addition to read as follows:

> That our AMA-RFS work with the ACGME to study resident burnout and determine if (1) recommendations can be made on how to recognize burnout, how to treat it, and, if possible, how to prevent it; (2) it relates to the professionalism core competency for residents; and (3) recognizing, treating and possibly preventing burnout could be included in the program requirements for residency program directors, <u>(4) measuring burnout (Maslach Burnout Inventory, MBI, Human Services Survey for Medical Personnel) and work-life balance (Areas of Worklife Survey--AWS) required for all medical trainees every 6 months</u>; and be it further

RESOLVED, That our AMA amend policy “Access to Confidential Health Services for Medical Students and Physicians” H-295.858 by addition and deletion as follows:

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, with the last option being reasonable proximity to the education/training site;

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. This includes protected educational time such that during scheduled didactics residents and fellows should be released from clinical duties, including answering non-urgent pages, and that covering physicians during this time should be attending physicians;

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 re-licensure 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 that are already working on physician burnout projects, such as American Psychiatric Association (APA), to encourage research into identifying, implementing programs such as Wellbeing Toolbox, and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups consisting of students and house staff in various stages of their education meeting one (lunch) hour every 4 weeks in small group settings; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members by ensuring that students, residents, and fellows have at least one half work day off every 6 months for mental health rejuvenation; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

Fiscal Note: MBI and AWS (for individual $15 for each test, for group $200 for each test).

References:

1. Shanafelt T. Mayo Clin Proc. 2015
2. Maria Panagioti et al. Association Between Physician Burnout and Patient Safety, Professionalism, and Patient Satisfaction: A Systematic Review and Meta-analysis. JAMA. Sept 2018. doi:10.1001/jamainternmed.2018.3713
3. Schernhammer E. NEJM 2005
4. Andrew and Brenner 2015, APA 2018
5. APA Wellbeing Ambassador Toolkit. Jan 2018. APA-Well-being-Ambassador-Toolkit-Challenges-and-Opportunities
6. Tait Shanafelt and John Noseworthy. Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout. Jan 2017. doi: 10.1016/j.mayocp.2016.10.004
7. American Psychiatric Association. Wellness Toolkit. https://www.psychiatry.org/psychiatrists/practice/well-being-and-burnout/well-being-resources.
8. Protected Block Curriculum Enhances Learning During General Surgery Residency Training JAMA SURGERY Webb, Weigelt, Redlich et. al “A protected block curriculum enhanced surgical residents' learning compared with a traditional model. Improvement in medical knowledge was easiest to measure, but performance in other Accreditation Council for Graduate Medical Education competency areas also demonstrated improvement” https://jamanetwork.com/journals/jamasurgery/fullarticle/404546
9. Legino et al Is Resident-Protected Time Really Protected? 2017 http://www.asc-abstracts.org/abs2017/56-19-is-resident-protected-time-really-protected/

Relevant RFS & AMA Policy:

291.015R Intern and Resident Burnout
That our AMA-RFS work with the ACGME to study resident burnout and determine if (1) recommendations can be made on how to recognize burnout, how to treat it, and, if possible, how to prevent it; (2) it relates to the professionalism core competency for residents; and (3) recognizing, treating and possibly preventing burnout could be included in the program requirements for residency program directors. [Resolution 3, A-06; Reaffirmed Report D, I-16]

H-295.993 Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs
Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services. [Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08; Modified: CME Rep. 01, A-18]

H-295.858 Access to Confidential Health Services for Medical Students and Physicians
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 re-licensure 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.
6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.
7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach. [CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18]

H-405.957 Programs on Managing Physician Stress and Burnout
1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students. [Res. 15, A-15; Appended: Res. 608, A-16]

H-310.907 AMA Duty Hours Policy
Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training:
1. Our AMA reaffirms support of the 2003 Accreditation Council for Graduate Medical Education (ACGME) duty hour standards.
2. Our AMA will continue to monitor the enforcement and impact of duty hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.
3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.
4. Our AMA endorses the study of innovative models of duty hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific duty hours requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.
5. Our AMA encourages the ACGME to:
a) Decrease the barriers to reporting of both duty hour violations and resident intimidation.
b) Ensure that readily accessible, timely and accurate information about duty hours is not constrained by the cycle of ACGME survey visits.
c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of resident duty hour rules.
d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of duty hours.
6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:
a) Offer incentives to programs/institutions to ensure compliance with duty hour standards.

b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.
c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.
d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.
7. Our AMA supports the following statements related to duty hours:
a) Resident physician total duty hours must not exceed 80 hours per week, averaged over a four-week period (Note: Total duty hours includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).
b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.
c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."
f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, duty hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, to the 16-hour shift limit for first-year residents, or allowing a limited increase to the total number of duty hours when need is demonstrated.
g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.
h) Duty hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians.
i) Scheduled time providing patient care services of limited or no educational value should be minimized.
j) Accurate, honest, and complete reporting of resident duty hours is an essential element of medical professionalism and ethics.
k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of duty hour regulations, and opposes any regulatory or legislative proposals to limit the duty hours of practicing physicians.
l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.
m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.
n) The costs of duty hour limits should be borne by all health care payers.
o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.
8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety. [CME Rep. 5, A-14]

D-310.968 Physician and Medical Student Burnout
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, and fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage the Accreditation Council for Graduate Medical Education and the Association of American Medical Colleges to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout. [CME Rep. 8, A-07; Modified: Res. 919, I-11]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 9
(I-18)

Introduced by: SCOTT H PASICHOW, MD, MPH

Subject: MEDICAL AID IN DYING

Referred to: Reference Committee

Whereas, At AMA Annual 2018 the Council on Ethical and Judicial Affairs Report 5 addressed this topic and recommended that no changes be made to the code of medical ethics, and that the term “physician assisted suicide” was more precise and should be used;[1] and

Whereas, This report was referred for return report at a later date yet to be defined;[1] and

Whereas, Policy H-140.952 states “Physician-assisted suicide is fundamentally incompatible with the physician’s professional role;[2]” and

Whereas, Policy H-270.965 directs our AMA to “strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer;[2]” and

Whereas, Policy H-140.966 states “Physicians must not perform euthanasia or participate in assisted suicide;[2]” and

Whereas, Seven states and the District of Columbia currently have laws which allow for some form of aid in dying;[2] and

Whereas, The processes by which someone is deemed eligible for a prescription for medication which they can self-administer to end their life involves multiple requests separated by time, written and oral requests, informed consent, discussions of palliative care and other alternatives to aid in dying, and a referral to a licensed provider so that two physicians certify that the patient is physically and decisionally capable, informed, and agreeable, and may include a mental health evaluation when requested;[3] and

Whereas, The American Society of Hospice and Palliative Care (ASHPC) is reserved in their neutrality on the issue, citing potential unintended consequences, but does not feel that, at this time, the practice should be completely prohibited;[4] and

Whereas, The Nevada State Medical Association, Maine Medical Association, Oregon Medical Association, Medical Society of the District of Columbia, Maryland State Medical Society, and Massachusetts Medical Society have all taken neutral stances on the issue over the past 20 years;[5] and

Whereas, The Colorado Medical Society’s policy on Physician-Assisted Death states “Physicians and patients should be allowed to pursue options that do not violate either party’s fundamental values;[6]” and

Whereas, In 2015, the California Medical Society removed policy that opposed aid in dying;[5] and

Whereas, the American Medical Student Association (AMSA) has policy on Aid in Dying stating that the AMSA "SUPPORTS passage of aid in dying laws that empower terminally ill patients who have decisional capacity to hasten what might otherwise be a protracted, undignified or extremely painful death;[7]" and

Whereas, American Medical Women's Association, American Public Health Association, GLMA: Healthcare Professionals Advancing LGBT Equality, American College of Legal Medicine among other organizations support the ability for physicians and patients to choose to include aid in dying in their care plans where appropriate and support laws that allow for it;[5] and

Whereas, A 2016 Gallup Poll indicates that 69% of Americans support the idea that "when a person has a disease that cannot be cured...doctors should be allowed by law to end the patient's life by some painless means if the patient and their family request it;[8]" and

Whereas, All of the above listed reports referred to this practice as "Medical Aid-in-dying;"[5] therefore be it

RESOLVED, That our AMA-RFS support changes to AMA policy to support laws that allow for Medical Aid in Dying; and be it further

RESOLVED, That our AMA-RFS support changes to AMA policy to move the AMA towards public support of Medical Aid in Dying; and be it further

RESOLVED, That our AMA-RFS support changes to AMA policy which codify that it is within the AMA's Code of Medical Ethics for physicians to involve Medical Aid in Dying in their practice when allowed by law and agreed to by the patient and provider; and be it further

RESOLVED, That our AMA-RFS work with appropriate external organizations to ensure that resident and fellow training includes training in Medical Aid in Dying as allowed by law and at the discretion of the trainee, and support policy changes within the AMA which seek to do the same; and be it further

RESOLVED, That our AMA-RFS support the AMA in ending its practice of using the term "physician assisted suicide" and instead replace it with the term "Medical Aid in Dying."

Fiscal Note:

References:

1. Agliano DS. "Council on Ethical and Judicial Affairs Report 5-A-18." American Medical Association. https://www.ama-assn.org/sites/default/files/media-browser/public/hod/a18-refcomm-conby-annotated.pdf.
2. AMA Policy Finder. https://www.ama-assn.org/about-us/policyfinder
3. "End of Life Option Act." Coalition for Compassionate Care of California. https://coalitionccc.org/tools-resources/end-of-life-option-act/. Revised 2018 June 15.
4. Board of Directors. "Statement on Physician Assisted Dying." American Academy of Hospice and Palliative Medicine. http://aahpm.org/positions/pad. 2016 June 24.
5. "Medical Professional Associations that Recognize Medical Aid in Dying." Compassion and Choices. https://www.compassionandchoices.org/wp-content/uploads/2016/02/FS-Medical-Professional-Associations-that-Recognize-Medical-Aid-in-Dying-FINAL-9.27.17-Approved-for-Public-Distribution.pdf. 2017 Sept 27.

6. Board of Directors. “Policy 170.994 Euthanasia and Physician Assisted Death.” Colorado Medical Society. http://www.cms.org/about/policies/170.994-euthanasia-and-physician-assisted-suicide. 2016 Sept 16.
7. "Policies" (PDF). American Medical Student Association. http://www.amsa.org/wp-content/uploads/2015/03/PPP-2015.pdf. 2016-12-01.
8. Smith, Michael. "Euthanasia Still Acceptable to Solid Majority in U.S." Gallup. Retrieved 2016 Dec 01.

Relevant RFS & AMA Policy:

100.002R Physician-Assisted Suicide
That our AMA-RFS support AMA's effort to provide national leadership through sponsorship of forums and dissemination of information regarding the ethical dilemma of physician-assisted suicide and other end of life decisions. (Substitute Resolution 28, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-12).

H-140.952 Physician Assisted Suicide
It is the policy of the AMA that:
(1) Physician assisted suicide is fundamentally inconsistent with the physician's professional role.
(2) It is critical that the medical profession redouble its efforts to ensure that dying patients are provided optimal treatment for their pain and other discomfort. The use of more aggressive comfort care measures, including greater reliance on hospice care, can alleviate the physical and emotional suffering that dying patients experience. Evaluation and treatment by a health professional with expertise in the psychiatric aspects of terminal illness can often alleviate the suffering that leads a patient to desire assisted suicide.
(3) Physicians must resist the natural tendency to withdraw physically and emotionally from their terminally ill patients. When the treatment goals for a patient in the end stages of a terminal illness shift from curative efforts to comfort care, the level of physician involvement in the patient's care should in no way decrease.
(4) Requests for physician assisted suicide should be a signal to the physician that the patient's needs are unmet and further evaluation to identify the elements contributing to the patient's suffering is necessary. Multidisciplinary intervention, including specialty consultation, pastoral care, family counseling and other modalities, should be sought as clinically indicated.
(5) Further efforts to educate physicians about advanced pain management techniques, both at the undergraduate and graduate levels, are necessary to overcome any shortcomings in this area. Physicians should recognize that courts and regulatory bodies readily distinguish between use of narcotic drugs to relieve pain in dying patients and use in other situations. [CEJA Rep. 8, I-93; Reaffirmed by BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99; Reaffirmed: CEJA Rep. 8, A-09]

H-140.966 Decisions Near the End of Life
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration. (2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment. (3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide. (4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time. (5) Our AMA supports continued research into and education concerning pain management. [CEJA Rep. B, A-91; Reaffirmed by BOT Rep. 59, A-96; Reaffirmation A-97; Appended: Sub. Res. 514, I-00; Reaffirmed: CEJA Rep. 6, A-10]

H-270.965 Physician-Assisted Suicide
Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer. [Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, A-08; Reaffirmed: BOT Rep. 09, A-18]

H-140.949 Physician-Assisted Suicide
The AMA will (1) initiate an educational campaign to make palliative treatment and care directions based on values-based advance care planning the standard of care for meeting the needs of patients at the end of life; and (2) will work with local, state, and specialty medical societies to develop programs to: facilitate referrals to physicians qualified to provide necessary palliative and other care for patients seeking help in meeting their physiological and psychological needs at the end of life; and establish a faculty of physicians with expertise in end-of-life care who can provide consultations for other physicians in caring for patients at the end of life. [BOT Rep. 59, A-96; Reaffirm: Res. 237, A-99; Reaffirmed: CEJA Rep. 8, A-09]

5.7 Physician-Assisted Suicide: AMA Code of Medical Ethics
Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).
It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.
Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:
(a) Should not abandon a patient once it is determined that cure is impossible.
(b) Must respect patient autonomy.
(c) Must provide good communication and emotional support.
(d) Must provide appropriate comfort care and adequate pain control.
AMA Principles of Medical Ethics: I,IV
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. [2016]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 10
(I-18)

Introduced by: NIKESH BAJAJ, DO, CHRISTIANA SHOUSHTARI, MD

Subject: IMPROVING PATIENT CARE THROUGH PATIENT SELF-AWARENESS OF PERSONAL HEALTH INFORMATION

Referred to: Reference Committee

Whereas, Many patients or their caretakers are unaware of their own medical problem lists, medication regimens, or past medical testing information.[1,2] This information will inclusively be referred to as Patient Health Information (PHI); and

Whereas, This is to be distinguished from health literacy, as health literacy infers that the patients understand their conditions or medications;[3] and

Whereas, Determining a problem list, medication list, or attempting to elicit results of previous testing can be time consuming, and if not completed, can lead to serious medical consequences; and

Whereas, While health literacy rates may be low, it may still be possible for patients to keep track of their own PHI in a database-type format to improve health outcomes, although this has not yet been studied; and

Whereas, In common situations of low health literacy, a patient may not necessarily be expected to fully understand his/her medical problems or management, but keeping a database of information for a new healthcare provider may itself be beneficial for patient care; and

Whereas, The creation of smartphone software may be one possible method to improve patient self-health data tracking; therefore be it

RESOLVED, That our AMA-RFS ask our AMA to evaluate methods to garner patient responsibility to provide Protected Health Information (PHI) to their healthcare providers, and be it further

RESOLVED, That our AMA-RFS ask our AMA to study the impact such methods may have on health outcomes.

Fiscal Note:

References:

1. Ofri, Danielle. “A Doctor's Guide to a Good Appointment.” The New York Times, The New York Times, www.nytimes.com/guides/well/make-the-most-of-your-doctor-appointment.
2. Putting Pre-Visit Planning into Practice. Christine A. Sinsky, MD, FACP, Thomas A. Sinsky, MD, FACP, and Ellie Rajcevich. Fam Pract Manag. 2015 Nov-Dec;22(6):30-38.
3. Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low health literacy and health outcomes: an updated systematic review. Ann Intern Med. 2011 Jul 19;155(2):97-107. doi: 10.7326/0003-4819-155-2-201107190-00005. Review. PubMed PMID: 21768583.

Relevant RFS & AMA Policy:

D-478.979 Promoting Internet-Based Electronic Health Records and Personal Health Records
Our American Medical Association will advocate for the Centers for Medicare & Medicaid Services (CMS) to evaluate the barriers and best practices for those physicians who elect to use a patient portal or interface to a personal health record (PHR) and will work with CMS to educate physicians about the barriers to PHR implementation, how to best minimize risks associated with PHR use and implementation, and best practices for physician use of a patient portal or interface to a PHR. [BOT Rep. 11, I-11]

H-315.971 Patient Information in the Electronic Medical Record
(5) Physicians retain the right to determine which information they do and/or do not import from a PHR into their EHR/EMR and to set parameters based on the clinical relevance of data contained within personal health records.
(6) Any data imported into a physician's EMR/EHR from a patient's personal health record (PHR) must preserve the source information of the original data and be further identified as to the PHR from which it was imported as additional source information to preserve an accurate audit trail.
(7) In order to maintain the legitimate recording of clinical events, patients should not be able to delete any health information in the record. Rather, in order to maintain the forensic nature of the record, patients should only be able to add notations when appropriate.
(8) Disclosures of Personal Health Information should comply with all applicable federal and state laws, privileges recognized in federal or state law, including common law, and the ethical requirements of physicians. [BOT Rep. 19, A-07; Modified: BOT Rep. 16, A-10]

H-450.938 Value-Based Decision-Making in the Health Care System
5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making. [CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmation I-14; Reaffirmation: I-17]

H-185.979 Allocation of Health Services
(3) utilize all appropriate consumer health information channels to encourage the development by individuals and families of personal health records containing information on family and medical histories and problems, care received, medications, immunizations, allergies, and other relevant medical information and to explore the feasibility of developing sample formats for such personal health records. [BOT Rep. I-93-22; Reaffirmation A-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmation A-10]

H-406.987 Medical Information and Its Uses
DATA TRANSPARENCY PRINCIPLES TO PROMOTE IMPROVEMENTS IN QUALITY AND CARE DELIVERY
Our AMA seeks to help physicians improve the quality reporting of patient care data and adapt to new payment and delivery models to transform our health care system. One means of accomplishing this goal is to increase the transparency of health care data. The principles outlined below ensure that physicians, practices, care systems, physician-led organizations, patients and other relevant stakeholders can access and proactively use meaningful, actionable health care information to achieve care improvements and innovations. These principles do not replace but build upon existing AMA policies H-406.990, H-406.989, H-406.991, and H-406.996 that address safeguards for the release of physician data and physician profiles, expanding these guidelines to reflect the new opportunities and potential uses of this information.

Transparency Objectives and Goals
Engaging Physicians - Our AMA encourages greater physician engagement in transparency efforts, including the development of physician-led quality measures to ensure that gaps in measures are minimized and that analyses reflect the knowledge and expertise of physicians.
Promoting New Payment and Delivery Models - Our AMA supports appropriate funding and other support to ensure that the data that are used to inform new payment and delivery models are readily available and do not impose a new cost or additional burden on model participants.

Improving Care Choices and Decisions - Our AMA promotes efforts to present data appropriately depending on the objective and the relevant end-user, including transparently identifying what information is being provided, for what purpose, and how the information can or cannot be used to influence care choices.
Informing Physicians - Our AMA encourages the development of user interfaces that allow physicians or their staff to structure simple queries to obtain and track actionable reports related to specific patients, peer comparisons, provider-level resource use, practice patterns, and other relevant information.
Informing Patients - Our AMA encourages patients to consult with physicians to understand and navigate health care transparency and data efforts.
Informing Other Consumers - Our AMA seeks opportunities to engage with other stakeholders to facilitate physician involvement and more proactive use of health care data.

Data Transparency Resources
Data Availability - Our AMA supports removing barriers to accessing additional information from other payers and care settings, focusing on data that is valid, reliable, and complete.
Access to Timely Data - While some datasets will require more frequent updates than others, our AMA encourages use of the most current information and that governmental reports are made available, at a minimum, from the previous quarter.
Accurate Data - Our AMA supports proper oversight of entities accessing and using health care data, and more stringent safeguards for public reporting, so that information is accurate, transparent, and appropriately used.
Use of Quality Data - Our AMA supports definitions of quality based on evidence-based guidelines, measures developed and supported by specialty societies, and physician-developed metrics that focus on patient outcomes and engagement.
Increasing Data Utility - Our AMA promotes efforts by clinical data registries, regional collaborations, Qualified Entities, and specialty societies to develop reliable and valid performance measures, increase data utility and reduce barriers that currently limit access to and use of the health care data.

Challenges to Transparency
Standardization - Our AMA supports improvements in electronic health records (EHRs) and other technology to capture and access data in uniform formats.
Mitigating Administrative Burden - To reduce burdens, data reporting requirements imposed on physicians should be limited to the information proven to improve clinical practice. Collection, reporting, and review of all other data and information should be voluntary.
Data Attribution - Our AMA seeks to ensure that those compiling and using the data avoid attribution errors by working to correctly assign services and patients to the appropriate provider(s) as well as allowing entities to verify who or where procedures, services, and items were performed, ordered, or otherwise provided. Until problems with the current state of episode of care and attribution methodologies are resolved, our AMA encourages public data and analyses primarily focused at the system-level instead of on individual physicians or providers. [BOT Rep. 6, A-15]

D-478.972 EHR Interoperability
Our AMA: (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System; (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange; (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges; (4) will continue efforts to promote interoperability of EHRs and clinical registries; (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates; (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private; (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care; and (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data. [Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16;

Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18]

Code of Medical Ethics: Opinions on Privacy, Confidentiality & Medical Records (3.2 Confidentiality)
Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient. In general, patients are entitled to decide whether and to whom their personal health information is disclosed. However, specific consent is not required in all situations. [2016]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 11
(I-18)

Introduced by: TANI MALHOTRA, MD; RAGHUVEER PUTTAGUNTA, MD

Subject: DELEGATION OF INFORMED CONSENT

Referred to: Reference Committee

Whereas, The process of witnessed informed consent is a vital prerequisite to any invasive procedure or treatment, and constitutes a detailed back-and-forth discussion between the healthcare team and the patient regarding specific risks, benefits, indications and alternatives of that particular procedure or treatment; and

Whereas, Many physician groups and departments of physicians (particularly, specialists and subspecialists) frequently work as a well-organized "team" in order to better care for the patient and to improve the efficiency of patient care; and

Whereas, Allowing other qualified members of the health care team to participate in the informed care process may provide the patient with more information, more opportunities to ask questions and, ultimately, to be able to make an informed decision; and

Whereas, There are many situations when it is impractical to prohibit other competent members of the health care team (residents, nurses, physician assistants) to participate in the informed consent process; and

Whereas, The process of obtaining informed consent is a vital component in residency training to produce a competent independent physician; and

Whereas, A 2017 Pennsylvania Supreme Court ruling (*Shinal v. Toms*) mandated that a physician may not delegate to others his or her obligation to provide sufficient information to obtain a patient's informed consent[1]; and

Whereas, The Pennsylvania Supreme Court further stated in its judgment that the duty of informed consent is a non-delegable duty owed by the physician conducting the surgery or treatment; and

Whereas, This legal ruling may lead to a precedent with potential devastating and adverse unintended consequences to patient health by causing unnecessary and potentially harmful delays across the country; therefore, be it

RESOLVED, That our AMA in cooperation with other relevant stakeholders advocate that a qualified physician be able to delegate his or her duty to obtain informed consent to another provider that has knowledge of the patient, the patient's condition, and the procedures to be performed on the patient.

Fiscal Note:

References:

1. Shinal v. Toms, 2017 WL 2655387, at *17 (Pa. June 20, 2017).

Relevant RFS and AMA Policy:

AMA Code of Medical Ethics 2.1.1 - Informed Consent
Informed consent to medical treatment is fundamental in both ethics and law. Patients Have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making.

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
(b) present relevant information accurately and sensitively in keeping with the patient's preferences for receiving medical information.
(c) document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record. (Issued 2016)

H320.951 – AMA opposition to "Procedure-Specific" Informed Consent
Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure. (Res. 226, A-99 Reaffirmed: Res. 703, A-00 Reaffirmed: BOT Rep. 6, A-10)

H140.989 – Informed Consent and Decision-Making in Health Care
(1) Health care professional should inform patients of their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the healthcare professional, cause serious harm to the patient. (BOT Rep. NN, A-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: Res. 408, A-02 Reaffirmed: BOT Rep. 19, I-06 Reaffirmation A-07 Reaffirmation A-09)

AMA-RFS RESOLUTIONS IN HOUSE OF DELEGATES

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911
(I-18)

Introduced by: Resident and Fellow Section

Subject: Regulating Tattoo and Permanent Makeup Inks

Referred to: Reference Committee K

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 organized 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[4], 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[5]; 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 be it

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 study the safety of any chemical in tattoo and permanent makeup Inks.

Fiscal Note:

References:

1. Laumann AE, Derick AJ. Tattoos and body piercings in the United States: a national data set. Journal of the American Academy of Dermatology. 2006 Sep 30;55(3):413-21.
2. https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm048919.htm
3. http://theconversation.com/one-in-five-tattoo-inks-in-australia-contain- carcinogenic-chemicals-63947
4. Laumann AE, Derick AJ. Tattoos and body piercings in the United States: a national data set. Journal of the American Academy of Dermatology. 2006 Sep 30;55(3):413-21.
5. https://search.coe.int/cm/Pages/result_details.aspx?ObjectID=09000016805d3dc4

Relevant AMA Policy:

H-440.909 Regulation of Tattoo Artists and Facilities

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)

H-440.934 Adequacy of Sterilization in Commercial Enterprises

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)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 953
(I-18)

Introduced by: Resident and Fellow Section

Subject: Support for the Income-Driven Repayment Plans

Referred to: Reference Committee K

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)[1]; 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[1-3]; 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 advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden.

Fiscal Note:

References:

1. https://www.gao.gov/products/GAO-17-22
2. https://www.washingtonpost.com/news/grade-point/wp/2017/05/17/trump-and-devos-plan-to-reshape-higher-education-finance-heres-what-it-might-mean-for-you/?utm_term=.45d5f0a6d200
3. https://www.cnbc.com/2017/05/24/trumps-budget-seeks-to-cut- one-major-benefit-of-federal-student-loans.html

Relevant AMA Policy:

H-305.965 Student Loans
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)

D-305.978 Mechanisms to Reduce Medical Student Debt
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)

D-305.980 Immediate Legislative Solutions to Medical Student Debt
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)

D-305.984 Reduction in Student Loan Interest Rates
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)

D-305.993 Medical School Financing, Tuition, and Student Debt
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)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 951
(I-18)

Introduced by: Resident and Fellow Section

Subject: Prevention of Physician and Medical Student Suicide

Referred to: Reference Committee K

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 request that the Liaison Committee on Medical Education and Accreditation Council of Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events.

Fiscal Note:

References:

1. https://www.fastcompany.com/3056015/thehiddenepidemicofdoctorsuicides
2. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3549025/#idm140038005580816aff-infotitle
3. http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0150246

Relevant AMA Policy:

H-295.858 Access to Confidential Health Services for Medical Students and Physicians

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)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 912
(I-18)

Introduced by: Resident and Fellow Section

Subject: Comprehensive Breast Cancer Treatment

Referred to: Reference Committee K

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

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

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

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

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

Whereas, Breast reconstruction has been shown to significantly increase physical, social and sexual well-being[1]; therefore be it

RESOLVED, That our AMA amend Policy H55.973 by addition and deletion as follows:

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

Fiscal Note:

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

RELEVANT AMA POLICY

H-55.973 Breast Reconstruction
Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the postmastectomy cancer patient should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-18)

Introduced by: Resident and Fellow Section

Subject: Support for the Development and Distribution of HIPAA-Compliant Communication Technologies

Referred to: Reference Committee B

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 hereas, The AMA has guidelines that expect all institutions to provide retirement benefits; 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[1]; and

Whereas, Baseline cell phone security, text messaging and telecommunication technologies are lacking in necessary security measures to meet the standards for HIPAA-compliance[2,3]; 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[3,4]; therefore be it

RESOLVED, That our AMA promote the development and use of HIPAA-compliant technologies for text messaging, electronic mail and video conferencing

Fiscal Note:

References:

1. https://www.informationweek.com/healthcare/security-and-privacy/hipaa-compliance-what- every-developer-should-know/a/d-id/1297180
2. http://library.ahima.org/doc?oid=105342#.WbdYl9hOmEc
3. https://link.springer.com/article/10.1007/s10916-016- 0489-2
4. http://onlinelibrary.wiley.com/doi/10.1002/jhm.2228/full

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 email 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)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-18)

Introduced by: Resident and Fellow Section

Subject: Restriction on IMG Moonlighting

Referred to: Reference Committee B

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

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

Whereas, Foreign-born IMGs were more likely to practice in rural underserved areas than US born IMGs[2]; and

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

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

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

RESOLVED, That our AMA advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight.

Fiscal Note: Minimal

RELEVANT AMA POLICY

H-255.970 Employment of Non-Certified IMGs
Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs.

References:
[1] Research Shows Shortage of More than 100,000 Doctors by 2030. Available at: https://news.aamc.org/medical-education/article/new-aamc-research-reaffirms-looming-physician-shor/.
[2] International Medical Graduates and The Primary Care Workforce For Rural Underserved Areas. Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.22.2.255.
[3] Employment Outside of the Approved Training Program ("Moonlighting"). Available at https://www.ecfmg.org/evsp/evspemot.pdf.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-18)

Introduced by: Resident and Fellow Section

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

Referred to: Reference Committee J

Whereas, "Dense breast" tissue makes it harder to identify cancer on a mammogram, especially if there are no calcifications present within the cancer[1]; and

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

Whereas, A "negative" screening mammography result does not reliably rule out cancer in women with dense breasts[1]; and

Whereas, These women with "dense breast" tissue often have higher stage cancers upon detection due to the fact that they are not discovered until they are larger and symptomatic[1]; and

Whereas, Ultrasound and MRI have been shown to reduce interval cancers in women with "dense breasts"[1]; and

Whereas, Approximately 30 states have adopted laws requiring notification to patients with "dense breasts"[2]; and

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

Whereas, Insurance companies are not required to pay for additional screening[3]; therefore be it

RESOLVED, That our AMA support insurance coverage for supplemental screening recommended for patients with "dense breast" tissue following a conversation between the patient and their physician; and be it further

RESOLVED, That our AMA advocate for insurance coverage for and adequate access to supplemental screening recommended for patients with "dense breast" tissue following a conversation between the patient and their physician.

Fiscal Note:

References:

1. Berg WA. Supplemental Breast Cancer Screening in Women with Dense Breasts Should be Offered with Simultaneous Collection of Outcomes Data. *Annals of internal medicine*. 2016;164(4):299-300. doi:10.7326/M15- 2977.
2. Breast Density Notification Laws by State — Interactive Map. Available at http://www.diagnosticimaging.com/breast- imaging/breast-density-notification-laws-state--interactive-map.
3. Dense Breast Info. Available at http://densebreast-info.org/legislation.aspx.

Relevant AMA Policy:

H-525.993 Screening Mammography
Our AMA: a. recognizes the mortality reduction benefit of screening mammography and supports its use as a tool to detect breast cancer. b. recognizes that as with all medical screening procedures there are small, but not inconsequential associated risks including false positive and false negative results and overdiagnosis. c. favors participation in and support of the efforts of professional, voluntary, and government organizations to educate physicians and the public regarding the value of screening mammography in reducing breast cancer mortality, as well as its limitations. d. advocates remaining alert to new epidemiological findings regarding screening mammography and encourages the periodic reconsideration of these recommendations as more epidemiological data become available. e. believes that beginning at the age of 40 years, all women should be eligible for screening mammography. f. encourages physicians to regularly discuss with their individual patients the benefits and risks of screening mammography, and whether screening is appropriate for each clinical situation given that the balance of benefits and risks will be viewed differently by each patient. g. encourages physicians to inquire about and update each patient's family history to detect red flags for hereditary cancer and to consider other risk factors
for breast cancer, so that recommendations for screening will be appropriate. h. supports insurance coverage for screening mammography. i. supports seeking common recommendations with other organizations, informed and respectful dialogue as guideline-making groups address the similarities and differences among their respective recommendations, and adherence to standards that ensure guidelines are unbiased, valid and trustworthy. j. reiterates its longstanding position that all medical care decisions should occur only after thoughtful deliberation between patients and physicians.

AMA-RFS INFORMATIONAL REPORTS

AMERICAN MEDICAL ASSOCIATION-RESIDENT AND FELLOW SECTION

Informational Report: A
(I-18)

Subject: AMA-RFS Organizational Report

Introduced by: RFS Governing Council
Colin Murphy MD, Chair

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 physicians and to train young physician leaders. With the support of members, your Resident and Fellow Section fights to improve working conditions, reform America's health care system, improve medical education, and create tools to help resident and fellow physicians succeed both personally and professionally.

The RFS has representation and direct involvement in all levels of the AMA. Resident and fellow physicians are represented through their own democratically elected, policy-making body; the RFS Assembly which meets twice a year. For over 26 years, the RFS has set policies that have directly impacted national legislation and the policies of regulating bodies. The AMA-RFS policy process gives you the power to create change and is one of the most unique and powerful privileges of membership.

Membership in the RFS ensures your voice is heard, not only in the AMA House of Delegates and throughout the AMA, but also in the legislative, executive and judicial branches of the federal government.

Leadership Opportunities

In addition to creating policies, the RFS has many leadership opportunities for residents and fellows.

AMA-RFS Governing Council – There are 8 positions on the Governing Council including Chair, Vice-Chair, Speaker, Vice-Speaker, Delegate, Alternate Delegate, Member-at Large, and Board of Trustees Liaison.

Delegates to the RFS Assembly – Delegates are selected by state medical societies, national medical specialty societies or professional interest medical associations to represent their resident and fellow membership or are At-Large Delegates who have applied to represent the general AMA resident and fellow membership. These Delegates have full voting privileges in the RFS Assembly and vote to establish RFS policy.

Assembly Convention Committees – The RFS has several involvement opportunities for residents and fellows interested in being active at the Annual and Interim meetings including the Reference Committee, Credentials Committee, Rules Committee, and Logistics Committee. Convention Committees are vital to the operation of the Assembly.

Standing Committees – There are 8 Standing Committees: 1) Committee on Long Range Planning; 2) Committee on Medical Education; 3) Legislative Advocacy Committee; 4) Membership Committee; 5) Committee on Scientific Research; 6) Public Health Committee; 7)

Council on Business and Economics and 8) Committee on Quality and Patient Safety. Standing Committees are appointed by the RFS-GC and assist the GC in furthering the mission of the Section.

Sectional Delegates – Sectional Delegates are elected by the RFS Assembly to represent the Section, in addition to their designated state or specialty society in the HOD. The number of Sectional Delegates is dependent on the total AMA resident and fellow membership; the Section gets one Sectional Delegate per 2,000 members. The Sectional Delegates also represent their sponsoring state or specialty society, and will often caucus with their societies.

Involvement

AMA Digital Communities
Turn to the AMA's digital platform to connect with experts on emerging trends in health care, discuss topics that matter to you and your peers and access moderated forums as well as AMA-curated expertise.

AMA Doctors Back to School program
Physicians and medical students visit schools and community organizations across the country to encourage children from underrepresented minority groups to consider a career in medicine.

AMA-FDA Internship Program
The FDA's Professional Affairs and Stakeholder Engagement Staff (PASES) offers an exclusive four-week elective rotation for AMA medical student, resident and fellowship trainee members to provide a focal point for advocacy and to enhance two-way communication and collaboration on issues concerning drug development.

AMPAC Campaign School
This multi-day program provides physicians with an understanding of how campaigns function and decisions are made. Accepted applicants receive a stipend to attend a weeklong "candidate" or "campaign manager" workshop in Washington D.C.

Junior Doctors Network (JDN)
Save the Date: Monday, October 9, 2017 at AMA Headquarters Conference Center.
A portion of the World Medical Association (WMA) meeting is designed for medical residents/fellows and young physicians who are members of the Junior Doctors Network. The WMA is an organization of leaders from national medical associations representing 112 countries and 8 million physicians around the world.

Resources

The following are some of the many resources and benefits available to you as one of more than 35,000 members of the AMA-RFS:

TEDMED
TEDMED, the health and medicine edition of the famous TED conference, is now open to AMA members! Access videos up-to one month after the conference (until December 3, 2017).

MACRA Resources - With physicians facing the most significant changes in Medicare in a generation, the AMA offers several online tools to help physicians through pending payment and delivery changes

AMA-RFS Facebook Page - Stay informed of all advocacy initiatives, awards, grants, internships, and leadership opportunities and discuss important issues affecting residents and fellows with your colleagues across the nation.

AMA Wire - Read up on issues that are important to residents and fellows.

Career Planning Resource - AMA's exclusive resource dedicated to helping you succeed personally and professionally as you manage the demands of training and today's evolving practice environment. This online tool offers information, insights and practical guidance covering important career stages on your radar right now: resident life and life in practice; drill into five hot topics relevant to all residents: wellness and preventing burnout, financial management, licensure education, disability insurance and planning, and coding documentation and requirements.

FREIDA Online - A database with over 8,400 graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education and ABMS Board-approved combined specialty programs.

Residency Vacancies - Locate programs seeking residents & fellows and employers seeking physicians.

Residency Work Environment - Learn about duty hour guidelines, reporting duty hour violations, Graduate Medical Education funding, resident income and debt relief, physician recruiter practices and much more.

JAMA CareerCenter® - A valuable resource for physician job seekers. One of the great benefits of membership is full access to physician career opportunities, news and information relevant to the entire spectrum of medical practice. You'll find job postings from virtually every specialty practice setting and region in the United States.

Visit the AMA-RFS Contracting page for tools to help you negotiate the best contract possible. Resources include: Model employment agreements that provide thorough descriptions of basic contract terms typically found in agreements, as well as in-depth explanations of the significance of such provisions and language that benefits the physician employee.

AMA STEPS Forward™ - These practice improvement strategies provide you with an in-depth look at how practices are implementing solutions to the challenges of today's evolving health care environment. This online resource will familiarize you with some of the ways physicians are improving practice efficiencies, patient experience and enhancing their professional satisfaction.

Health Workforce Mapper – This tool illustrates the distribution of physicians and non-physician clinicians by specialty, state, county, or metropolitan areas. This resource provides a useful visual tool to demonstrate to law- or policy-makers the geographic distribution of the healthcare workforce in a given state or nationally, to assist them in making appropriate, evidence-based decisions.

Public Health Resources - Covers a variety of important topics, including health disparities, disaster response, obesity assessment and management, infectious disease, adolescent health, dementia, geriatrics, etc.

Economic Impact Study – This study, completed in conjunction with state medical associations, shows how physicians helped boost the economy across the nation.

Email newsletter publications- Get news and information that helps you succeed as a medical student, resident and physician. Stay up to date with the latest news impacting health care and medicine to stay on the pulse of issues that matter to physicians and patients alike.

Awards & recognition-learn how the AMA recognizes physicians, residents and medical students who exemplify medicine's highest values.

Affinity Programs - Get AMA negotiated discounts on products and services. Check back on occasions since the AMA is continuing to expand these offerings.

If you have questions or would like additional information, please contact the members of the RFS Governing Council or RFS staff at (312) 464-5024.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Informational Report: B
(I-18)

Subject: AMA-RFS Advocacy Issues Update

Introduced by: RFS Governing Council
Colin Murphy, MD, Chair

Key Resources

AMA MACRA Center
Access the MACRA Center resources on Medicare payment and delivery changes here.

Patients before Politics
Get updates on Medicaid and other safety net programs, including ways for physicians and patients to take action, at the Patients before Politics website here.

Advocacy Resource Center (ARC)
The American Medical Association Advocacy Resource Center is a tireless advocate for physicians and their patients in coordination with state and national medical specialty societies. Explore ARC resources here.

Health Workforce Mapper
The interactive AMA Health Workforce Mapper illustrates the geographic distribution of the physician workforce and layers of patient health, demographic and health policy data. AMA members can view a comprehensive version of the tool and directly download data.

Physicians Impact on the Economy
The AMA Economic Impact Study quantifies that impact and underscores that physicians are vital economic drivers in local communities, contributing to better health care and a more productive society. Learn more here.

Federal and State Correspondence Finder
Learn about the AMA's state legislative and regulatory priorities, including recent advocacy achievements. Search correspondence here.

Physicians' Grassroots Network
Join the AMA's Physicians' Grassroots Network and receive timely updates, contact Congress and make a difference in the outcome of legislation. Learn more about ways to take action here.

AMA Advocacy Update
A bi-weekly newsletter that offers exclusive advocacy news and information on key national and state issues. Stay connected year-round. View the current issue and previous issues.

DACA Update

AMA advocates that "Dreamers" bolster physician workforce, should be allowed to stay
An estimated 5,400 previously ineligible physicians could be introduced into the U.S. health system over the coming decades through a DACA-like legislative fix. AMA Executive Vice

President and CEO James L. Madara, MD noted there is already a shortage of 8,200 primary care physicians—according to the Health Resources and Services Administration—and that the Association of American Medical Colleges has projected the total physician shortage could grow to as many as 94,700 doctors by 2025. Read the full letter here.

FDA Update

FDA announces efforts to increase generic drug competition

As part of the FDA's forthcoming Drug Competition Action Plan, FDA Commissioner Scott Gottlieb, MD intends to target anti-competitive actions of brand manufacturers when those companies engage activities that create obstacles to generic access. Read more here.

Opioid Epidemic Update

AMA launches opioid education microsite

As part of its continued advocacy efforts to help reverse the nation's opioid epidemic, the AMA last week launched a microsite focused on providing physicians with state- and specialty-specific education and training resources. The microsite, www.end-opioid-epidemic.org, includes nearly 300 education and training resources across three major categories. Click here for the AMA opioid microsite.

Regulatory Update

Dashboard tracks CMS moves toward regulatory relief

The Centers for Medicare and Medicaid Services (CMS) included several ideas for easing physician administrative burdens in its proposals for the second year of the Medicare Quality Payment Program (QPP) and the 2018 Medicare Physician Fee Schedule.The AMA is tracking these measures. Find the dashboard here.

Non-Discrimination Policy Update

AMA urges HHS Office of Civil Rights to retain sex-nondiscrimination policies

Following reports that the Trump administration may be revising its sex non-discrimination policies, the AMA has urged the HHS Office of Civil Rights (OCR) to retain its current policy of interpreting sex discrimination to include discrimination based on gender identity and sex stereotypes. Read the full letter here.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Informational Report: C
(I-18)

Introduced by: AMA-RFS Governing Council
Colin Murphy, MD, Chair

Subject: Fiscal Affairs

The American Medical Association-Resident and Fellow Section (AMA-RFS) Governing Council provides a fiscal affairs report to the Assembly at each Annual Meeting. The preparation of this report is in response to AMA-RFS Resolution 18 (A-78), reaffirmed at the 1998 and 2008 Interim Meetings. This report is presented for the information of the Assembly.

The AMA-RFS budget is subject to the same planning and monitoring process as other units within the AMA, and must receive final approval from the AMA's Board of Trustees. The AMA fiscal year begins January 1 and ends December 31.

The RFS budget is divided into five program budgets: Assembly Meetings, Governing Council, Research Symposium, Grants, and Staff. The total AMA-RFS operating budget is approximately $259,978 for 2018.

The total program budget for the RFS Governing Council and Assembly is $156,428 (not including staff compensation costs). This is approximately 60% of the budget and provides for the meeting expenses of the two Assembly meetings and three Governing Council meetings. The Research Symposium budget is $91,050 which is approximately 35% of the budget. Expenses covered include meeting room rental, equipment such as audio-visual, production of meeting material, postage and freight for meeting materials, supplies, travel, lodging, meals and speakers.

The AMA-RFS program budget also includes $2,000 to cover sponsored grants, awards and internships, federation relation and outreach, and participation on special councils and committees.

Update from the Ad Hoc Committee on Internal Operating Procedures Renewal

Purpose: This Ad Hoc Committee was assembled by the Governing Council to evaluate our Section's Internal Operating Procedures and develop recommendations and updates to be voted on by the General Assembly.

Background: Over the past several years there have been multiple attempts at changes to the IOPs. In some instances, these were related to modernizing or clarifying specific elements, in others the focus was a total overall. This resulted in piecemeal updates that did not address the larger inconsistencies and dated nature of our IOPs. This, combined with a confluence of external pressures, had resulted in perceived lack of progress in accomplishing a process initiated at least five years ago. Most recently, at Annual 2018, it was decided to form an Ad Hoc Committee tasked with completing the update.

Timeline: In accordance with the will of the Assembly, an update is due at Interim 2018, with a final draft to be presented and voted on at Annual 2019.

Focus: While the committee will complete a comprehensive review and update of the IOPs, there are several issues which have repeatedly caused extended discussion within the Assembly that will have special attention. Specifically these will include the role of the RFS caucus within the House of Delegates, the procedures and limitations of endorsements by our Section, and the codification and institutional memory of items of business approved by our Assembly.

Composition: The Ad Hoc Committee was selected by the Governing Council with a membership as follows:
Chair- Joshua Lesko
Vice Chair- Naiim Ali
Membership- Benjamin Meyer (Chair, CBE), Helene Nepomuceno (Vice Chair, CLRP), Scott Pasichow (Vice Chair, CLRP), Luke Selby (Member, CME)
GC Liaison- Hunter Pattison
CC&B Liaison- Ariel Anderson

Progress to Date:
August- committee members completed independent review of assigned sections and submitted draft language
September- committee members reviewed total first draft and submitted edits and recommendations
October- first draft submitted for open comment period by General Assembly

This concludes the progress report from the Ad Hoc Committee.

A-18
DELEGATES UPDATE

A-18 Delegates Update

During the A-18 meeting the American Medical Association (AMA) Resident and Fellow Section (RFS) delegation to the AMA House of Delegates (HOD) took ad hoc stances on the following items by caucus vote. The composition of the delegation may be found at the end of the report.

Resolution 001: Discriminatory Policies that Create Inequities in Health Care

1. Resolved Clauses:
   RESOLVED, That our American Medical Association speak against policies that are discriminatory and create even greater health disparities in medicine (Directive to Take Action); and be it further
   RESOLVED, That our AMA be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation. (Directive to Take Action)

2. Vote: Support, by affirmation, with 40 out of 52 members of the delegation present.

3. Rationale: Our RFS has broad policy opposing discrimination and supporting the specific asks within this resolution would fall under our umbrella policy. See 130.---R, CEJA Opinion E-8.115, CEJA report 6-A-07

4. Outcome in HoD: Adopted

Resolution 008: Healthcare Rights of Pregnant Minors

1. Resolved Clauses:
   RESOLVED, That our American Medical Association work with appropriate stakeholders to support legislation allowing pregnant minors to consent to related tests and procedures from the prenatal stage through postpartum care (Directive to Take Action); and be it further RESOLVED, That our AMA oppose any law or policy that prohibits a pregnant minor to consent to prenatal and other pregnancy related care, including, but not limited to, prenatal genetic testing, epidural block, and Cesarean section. (Directive to Take Action)

2. Vote: Support, by affirmation, with 40 out of 52 members of the delegation present.

3. Rationale: Our RFS has broad policy regarding women's health issues and opposing any restrictions therein, but needed to vote on this specific issue. See CEJA 2.2.1, CEJA 2.2.2, H60.958

4. Outcome in HoD: Adopted as Amended below
   RESOLVED, That our AMA oppose any law or policy that prohibits a pregnant minor <u>from</u> ~~to~~ consent<u>ing</u> to prenatal and other pregnancy related care, including, but not limited to, prenatal genetic testing, epidural block, <u>pain management,</u> Cesarean section, <u>diagnostic imaging, procedures, </u>and <u>emergency care</u>. (Directive to Take Action)

Resolution 209: Substance Use Disorders During Pregnancy

1. Resolved Clauses:
RESOLVED, That our American Medical Association reaffirm Policy H-420.969 (#4) so as to oppose any legislation that seeks to specifically penalize women who are diagnosed with a substance abuse disorder during pregnancy (Reaffirm HOD Policy); and be it further
RESOLVED, That our AMA oppose any efforts to imply that the diagnosis of substance abuse disorder during pregnancy represents child abuse (New HOD Policy); and be it further
RESOLVED, That our AMA support legislation for the expansion and improved access to evidence-based treatment for substance abuse disorders during pregnancy without mandating any specific form of therapy. (Directive to Take Action)

2. Vote: Support, by affirmation, with 40 out of 52 members of the delegation present.

3. Rationale: Our RFS has policy opposing criminal punishment for a pregnant woman whose behaviors are harmful to the fetus. Further, our Section is in support of providing rehabilitative treatments for such individuals as appropriate based on their condition. See 390.005R, H-420.962, H-420.969, H-430.987

4. Outcome in HoD: Adopt as Amended below
RESOLVED, That our AMA support legislative and other appropriate efforts ~~legislation~~ for the expansion and improved access to evidence-based treatment for substance ~~ab~~use disorders during pregnancy ~~without mandating any specific form of therapy~~. (Directive to Take Action)

Resolution 218: Considering Feminine Hygiene Products as Medical Necessities

1. Resolved Clauses:
RESOLVED, That our American Medical Association encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities.

2. Vote: Support, by affirmation, with 40 out of 52 members of the delegation present.

3. Rationale: Our RFS has existing policy supporting assistance for feminine hygiene products, but does not specifically advocate for their classification as a medical necessity. See 390.001R, H-270.953, H-320.942

4. Outcome in HoD: Amended by Addition of a Second Resolved Clause as below
RESOLVED, That our American Medical Association work with state and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women have affordable access to the appropriate type and quantity of feminine hygiene products including tampons for their needs.

Resolution 313: Financial Literacy for Medical Students and Residents

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

2. Vote: Support, by affirmation, with 38 out of 52 members of the delegation present.
3. Rationale: Our RFS does not have specific policy relating to this issue, but as the subject matter directly relates to residents it was decided that our delegation needs to take a position. See D-295.316, D-295.321, H-295.924, H-295.977

4. Outcome in HoD: Adopted as Amended below

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

Resolution 417: Reducing Disparities in Obstetric Outcomes, Maternal Morbidity, and Prenatal Care

1. Resolved Clauses:
RESOLVED, That our American Medical Association work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices in ethnic minorities to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality. (Directive to Take Action)

2. Vote: Support, by affirmation, with 40 out of 52 members of the delegation present.

3. Rationale: Our RFS has broad policy covering women's health issues and reducing health disparities, but it was felt that they did not adequately cover the topics addressed by this resolution. See 410.028R, H-350.974, D-420.993, H-420.995

4. Outcome in HoD: Adopted as Amended below
RESOLVED, That our American Medical Association work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices ~~in ethnic minorities~~ to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality in racial and ethnic minorities. (Directive to Take Action)

Resolution 522: Silence Science: EPA Proposed Data Policy

1. Resolved Clauses:
RESOLVED, That our American Medical Association submit comments during the public comment period, or join comments written by other medical organizations, to express concern with the U.S. Environmental Protection Agency's (EPA) proposal to limit the use of research studies published in peer reviewed scientific journals that describe the adverse health effects of exposure to air pollution and other environmental exposures (Directive to Take Action); and be it further
RESOLVED, That our AMA reaffirm the value and integrity of the journal peer review process by sending a letter to the EPA stating that studies that have been published in scientific peer reviewed journals should be used by the agency in informing EPA regulatory policy making. (Directive to Take Action)

2. Vote: Support, by affirmation, with 40 out of 52 members of the delegation present.

3. Rationale: Our delegation strongly believes in the role of science and facts in the determination of federal policy and thought it important that our RFS have a unified voice on this specific topic. See 7.2.1, H-220.930, H-60.975, H-460.899, H-460.976

4. Outcome in HoD: Referred to the Board of Trustees

Resolution 601: Creation of LGBTQ Health Specialty Section Council

1. Resolved Clauses:
RESOLVED, That our American Medical Association House of Delegates establish a Specialty Section Council on LGBTQ Health. (Directive to Take Action)

2. Vote: Support, by affirmation, with 40 out of 52 members of the delegation present.

3. Rationale: Our RFS has broad policy supporting LGBTQ-specific issues in health and wanted to support the creation of a Section Council that may adequately represent this community within the HoD. See 260.008R, B-7.0.8

4. Outcome in HoD: Adopted.

Delegation Composition
The composition of the delegation is listed below. Please note that changes occuring as individuals left the conference or joined other delegations will be reflected in-line. A special thanks to our reference committee team leaders, who helped lead the review of over 250 items of business. Their names will be bolded below.

Delegate- Joshua Lesko
Alternate Delegate- Taylor George

Sectional Delegates:
Naiim Ali (replaced by Ankit Agarwal), **Grayson Armstrong**, Hans Arora, Eudy Bosley, Kathleen Doo, Sean Figy, Stephanie Guarino, Jason Hall (replaced by Courtney Moors), Laura Halpin, Daisy Hassani (replaced by Melanie Mitta), **Mark Kashtan**, **Amar Kelkar**, Aaron Kithkart, **Raymond Lorenzoni**, **Michael Lubrano**, Benjamin Meyer, **Matthew McNelley**, Natosha Monfore, **Hunter Pattison**, Raghuveer Pattagunta, Scott Resnick, Luke Selby, Megan Srinivas, Kimberly Swartz (replaced by Taylor George), Christopher Wee, Monica Wood

Sectional Alternate Delegates:
Ankit Agarwal, Michelle Falcone, Logan Jones, Michael Metzner, Scott Pasichow, Keena Que, Kunj Patel (replaced by Joanne Loethen), Courtney Moors (replaced by Ariel Anderson), Laurel Bessey, Melanie Mitta (replaced by George Fryhofer), Carl Streed Jr., Erin Schwab, Valerie Lockhart, Jessica Cho, Alberto Bursian (replaced by Pratishta Koirala), Danniel Terveen, Toyin Okanlawon, Timothy Parker, Jacob Burns (replaced by Christopher Libby), Tani Malhotra, Sarah Marsicek, Colin Murphy, Rebecca Obeng.

This concludes the Delegate Report for A-18.

Josh Lesko, Delegate
Taylor George, Alternate Delegate

AMA-RFS INTERNAL OPERATING PROCEDURES

American Medical Association Resident and Fellow Section

Internal Operating Procedures*

I. Name

The name of this organization shall be the Resident and Fellow Section of the American Medical Association (AMA-RFS). This is a special section for resident and fellow physician members of the AMA as set forth in the AMA Bylaws 7.1.

II. Purpose and Principles

The purpose of the RFS shall be to provide resident and fellow participation in the activities of the AMA through adherence to the following principles:

A. To provide a direct means for members of the RFS to participate in the activities, including policy-making, of the AMA.

B. To enhance AMA outreach, communication, and interchange with the membership segments represented in the Sections.

C. To maintain effective communications and working relationships between the AMA and organizational entities that are relevant to the activities of each Section.

D. To promote AMA membership growth.

E. To enhance the ability of membership segments represented in the Sections to provide their perspective to the AMA and the House of Delegates.

F. To facilitate the development of information and educational activities on topics of interest to the membership segments represented in the Sections.

G. To promote the AMA Code of Medical Ethics among its resident and fellow members as well as the graduate medical education community.

H. To ensure that from the match through fellowship graduation, residents and fellows are treated fairly, regardless of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, or age and given the full opportunity to receive graduate medical education.

*Last revision: April 2016

III. Membership

Membership shall be limited to resident and fellow members of the AMA. Eligibility for resident and fellow membership is outlined in AMA Bylaws 7.1.1.

IV. Officers

A. Designations. The officers of the RFS shall be the 8 Governing Council members: Chair, Vice Chair, Delegate, Alternate Delegate, Speaker, Vice Speaker, Member at-Large, and Chair-elect/Immediate Past Chair (each serving 6 months). The Chair-elect/Immediate Past Chair shall be ex-officio, non-voting members of the Governing Council.

B. Authority. The Governing Council shall direct the programs and activities of the RFS. During the interval between meetings of the AMA House of Delegates and the RFS, the Governing Council shall act on behalf of the RFS in formulating decisions related to the development, administration, and implementation of RFS activities, programs, goals, and objectives. The Governing Council shall be guided by policy passed by the Assembly. The RFS shall be notified at least quarterly of actions taken by the Governing Council on its behalf.

C. Governing Council Eligibility. All members of the Governing Council must be resident and fellow members of the AMA or fourth-year medical students who have matched into a residency program. Any resident and fellow member of the AMA is eligible for a position on the RFS Governing Council. Eligible candidates must be AMA members prior to campaigning or running.

D. Duties and Privileges. The Governing Council shall direct the programs and activities of the RFS including the creation of RFS committees, subject to the approval of such programs and activities, when required, by the Board of Trustees or House of Delegates of the AMA. Each Governing Councilor is required to prepare in writing and communicate orally to his or her successor a description of his or her activities and where he or she sees the position going.

1. Chair. The Chair shall:

    a. Preside at all meetings of the Governing Council, and otherwise represent the RFS when appropriate.

    b. Preside at Assembly meetings if the Speaker and Vice Speaker positions are vacant, until such time that a successor may be elected.

c. Be the primary spokesperson for the RFS both inside the AMA and to outside organizations.

d. Have primary responsibility over setting the annual agenda.

2. Vice Chair. The Vice-Chair shall:

a. Preside at meetings of the Governing Council in the absence of the Chair or at the discretion of the Chair.

b. Assist the Chair in the performance of his or her duties, in particular with implementation of the annual agenda.

c. Have primary responsibility over coordinating internal operations of the RFS such as communication with Councilors, committees, the AMPAC Board member and all advocacy related issues including Lobby Day.

3. Delegate. The Delegate shall:

a. Represent in the AMA House of Delegates members of the Association who are residents and fellows.

b. Be responsible for reviewing all resolutions going forward from the RFS to the AMA HOD and summarize the actions of the HOD as they pertain to the RFS and send a summary of pertinent HOD actions to all RFS members.

c. Oversee which resolutions shall be forwarded to the House of Delegates. Decisions that differ from those of the Assembly must be ratified by the Assembly no later than the following meeting of the Assembly.

4. Alternate Delegate. The Alternate Delegate shall assist the Delegate in the duties of the Delegate and shall rise to the position of Delegate should the position fall vacant.

5. Member at-Large. The Member at-Large shall:

a. Coordinate the membership retention activities of the Governing Council.

b. Communicate involvement opportunities, AMA member benefits and other opportunities to current or potential resident and fellow members.

c. Work to coordinate medical student outreach programs to encourage continued involvement in the AMA as they transition from medical school to residency.

d. Assume a collaborative relationship with residents and fellows that have been appointed by the RFS to various Councils and Committees both internally and externally.

e. Foster the development of Resident and Fellow Sections in states where none exist and encourage them to send representatives to the AMA-RFS business meetings.

f. Serve as the Governing Council liaison to the membership standing committee.

6. Chair-elect. The Chair-elect shall:

a. Assist the other officers in the discharge of their duties.

b. Undertake to study the position of Chair in preparation of assuming this role.

c. With the assistance of the Chair, compose an agenda for his or her year of service prior to assuming the position of Chair.

7. Speaker. The Speaker shall:

a. With input from the Governing Council and AMA staff, create the agenda for the Annual and Interim meetings of the RFS Assembly. Ultimate decisions regarding meeting planning shall be those of the Speakers; however, the Speakers may be overruled by a 2/3 majority vote of the Governing Council.

b. Preside over the business meetings of the RFS Assembly in an impartial manner, organize and conduct them in accordance with the current parliamentary procedure authority as chosen by the AMA House of Delegates.

c. Provide for oversight and enforcement of the Campaign Rules, including responsibility for investigation of alleged infractions and reporting of actual infractions to the Assembly prior to balloting.

d. Organize and lead an orientation for new delegates and alternates at each Assembly meeting.

e. Work with the Governing Council in instructing the Convention Committees regarding their duties prior to each Assembly Meeting.

f. Refer resolutions and reports submitted for consideration at RFS Assembly business meetings to reference committees.

g. Prepare a document summarizing parliamentary procedure used in Assembly business meetings to be published in the RFS agenda book that is mailed to each Assembly representative prior to Assembly meetings.

h. Review the RFS Digest of Actions for consistency with Assembly action prior to its annual update and distribution.

i. In conjunction with the Vice Speaker, be the primary voice for the interests of the RFS Assembly on the RFS Governing Council.

8. Vice Speaker. The Vice Speaker shall:

a. Preside at meetings of the RFS Assembly during the absence of or at the request of the Speaker.

b. Assist the Speaker in the performance of his or her duties.

c. In conjunction with the Speaker, be the primary voice for the interests of the RFS Assembly on the RFS Governing Council.

d. With assistance from staff, coordinate the AMA-RFS Poster Competition.

E. Terms.

1. Chair-elect/Chair/Immediate Past Chair. Individual elected as Chair-elect shall serve a two-year term which will include 6 months as Chair-elect, one full year as Chair, and 6 months as Immediate Past Chair, beginning at the conclusion of the Interim meeting at which he or she was elected.

2. Delegate, Alternate Delegate, Member at-Large , Speaker, Vice Speaker and Vice-Chair. The remaining officers shall serve one-year terms, beginning at the conclusion of the Annual meeting at which they were elected and ending at the conclusion of the next Annual meeting of the AMA.

3. Term Limits. Any combination of service in Governing Council positions other than Chair-elect/Chair and Delegate shall be limited to 2 one-year terms. The Chair-elect/Chair, Delegate and Speaker may serve a

maximum of 2 years total in addition to 2 previous one-year terms in other Governing Council positions. Half-year positions to fill unexpired terms shall not count for the purpose of term limit calculations. The above limits shall be waived if they would result in a position being left vacant.

F. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Business Meeting of the Resident and Fellow Section. The new members shall be elected for the remainder of the unexpired term by the representatives to the Business Meeting.

1. **Temporary Appointment.** If a vacancy on the Governing Council occurs more than thirty (30) days prior to the next Business Meeting, the Governing Council may appoint a resident/fellow physician member of the AMA to fill the vacancy until the next Business Meeting of the Resident and Fellow Section when an election shall be held pursuant to rules adopted by the Resident and Fellow Section.

V. Elections to Governing Council

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

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

C. Eligibility.

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

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

position, resignation shall be allowed until the close of nominations on the floor of the Assembly.

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

D. Campaigns. Each candidate shall observe the following Campaign Rules:

1. Candidates may distribute only the following campaign materials:

   a. Buttons (less than 2 inches in greatest dimension).

   b. Stickers.

   c. Pins.

   d. Standard-size business cards.

   e. No trinkets, posters, candy, pens, or other items may be displayed or distributed.

2. Candidates are encouraged to have their curriculum vitae (CV) of no more than 3 single sided pages and personal statement of no more than one side of a page included in the AMA-RFS Agenda Book.

3. At the Assembly Meeting, distribution of CV's and personal statements will be limited to the back table of the Assembly room. It is the candidate's responsibility to make his or her materials available at the back table.

4. Candidates should be prudent and courteous regarding the number and content of advance mailings by themselves or constituent associations, specialty organizations, or other organizations on their behalf.

5. Candidates should be prudent and courteous regarding the number and content of electronic messages sent prior to the election.

6. Candidates are forbidden from using RFS listservs for messages regarding their campaign without express permission from the Speaker.

7. Candidates should use prudence in the number and length of phone calls made prior to the election.

8. Receptions and/or hospitality must not be used for promotion of a candidate(s).

9. Candidates are encouraged to fully participate in candidate interviews and question and answer sessions during the Assembly Meeting.

10. Groups (such as Regions or Caucuses) inviting candidates need to make available equal time for all candidates. If a group is unable to reasonably accommodate all candidates, no candidates shall be allowed to address the group. This rule shall not apply to a candidate addressing his or her own region.

11. Alleged infractions including but not limited to the Campaign Rules stated above should be reported in writing to the AMA-RFS Speaker or Vice Speaker who shall be responsible for their investigation. The AMA-RFS Speaker or Vice Speaker will report substantiated infractions to the Assembly prior to balloting. The Assembly should strongly consider any such announcement when voting for candidates.

E. Voter Eligibility. All credentialed RFS Assembly Delegates and Alternate Assembly Delegates shall be eligible to vote.

F. Method of Election. Where there is no contest, a majority vote without ballot may elect. All other elections shall be by ballot.

1. Voting Periods. There shall be one voting period at the Interim Meeting for the selection of the Chair-elect. There shall be one voting period at the Annual Meeting for the selection of the Vice Chair, Delegate, Speaker and Member At-Large Officer. An additional balloting period will be held for the elections of Alternate Delegate and Vice Speaker.

2. First Ballot.

    a. At the Interim Meeting, one ballot shall be used by the voter to elect with one vote for the position of Chair-elect.

    b. At the Annual Meeting, individual ballots for each position shall be used by the voter to elect with one vote for each of the 5 positions: the Vice Chair, Delegate, Speaker and Member At-Large Officer.

    c. A legal ballot shall list all candidates with their credentials in alphabetical order. The voter shall have one vote for each position.

Ballots shall be prepared and distributed by the Credentials Committee.

d. A ballot shall not be counted if there is more than one vote for any office on that ballot.

e. The candidate who receives a majority of legal votes cast for a given office shall be elected to that office.

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

3. Election of Alternate Delegate. After the election of the Delegate, all unsuccessful candidates who were nominated for the office of Delegate and who choose to be a candidate for Alternate Delegate will be placed on a ballot for the election of the Alternate Delegate. Additionally, any candidate who was nominated for the office of Alternate Delegate shall also be placed on the same ballot. Each voting Representative to the Business Meeting who is present at the meeting may cast a written ballot for the election of the Alternate Delegate from among those so nominated. Election to the office of Alternate Delegate requires a majority of the legal votes cast.

4. Election of Vice Speaker. After the election of the Speaker, all unsuccessful candidates who were nominated for the office of Speaker and who choose to be a candidate for Vice Speaker will be placed on a ballot for the election of the Vice Speaker. Additionally any candidate who was nominated for the office of Vice Speaker shall also be placed on the same ballot. Each voting Representative to the Business Meeting who is present at the meeting may cast a written ballot for the election of the Vice Speaker from among those so nominated. Election to the office of Vice Speaker requires a majority of the legal votes cast.

5. Processing.

a. All ballots will be returned to designated ballot boxes at a designated and fixed location in the Assembly hall. When each ballot is returned to the ballot box by a credentialed delegate, another ballot will be given to that delegate, by a member of the Credentials Committee to be used in any known necessary subsequent elections. The boxes will be monitored during the voting period by the Rules Committee.

b. No ballots will be cast after the expiration of each voting period; the ballot boxes will be collected by the members of the Rules Committee. The Rules Committee and the boxes will be sequestered in a private and secret location. At this time the Chair of the Rules Committee will open the ballot box and the Rules Committee will then count the ballots and tabulate the results. In the elections for the Governing Council, the candidate for each position who has received a majority of the votes cast shall be elected. If no nominee for a given position receives a majority of the votes cast, than the two candidates with the most votes will be placed on a subsequent ballot with all other candidates removed, and a subsequent vote shall take place. Following this vote, the candidate who receives a majority of legal votes cast shall be elected.

c. Upon completion of the tabulation, the Chair of the Rules Committee will validate the election results by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed and will then certify the results of the election in writing. He or she will then immediately forward these results to the Assembly's presiding officer.

d. Upon receipt of the Rules Committee's election results and verification, the presiding officer will announce the results to the Assembly.

e. Upon completion of all elections, the Assembly's presiding officer will certify in writing the results of these elections and announce to the Assembly the final and official results of these elections. Vote totals shall remain confidential and shall not be announced. Candidates may ask for and receive vote totals in confidence. Discretion is encouraged.

6. Appeals.

a. Appeals of the election process and results must be made in writing to the Assembly's presiding officer no later than one hour after the official announcement of the final results.

b. Any appeal of the process of ballot(s) distribution (as outlined in RFS Internal Operating Procedures V.E.2) will be considered by the Rules Committee. Consideration of such appeals and merits of said appeals will be determined in whatever manner the committee deems necessary. The results of the committee's recommendations must be forwarded in writing by the Committee Chair to the Assembly's presiding officer.

c. Any appeal of the process of ballot election, tabulation and announcement of results (as outlined in RFS Internal Operating Procedures V.E.7.a) shall be considered by the Rules Committee in the same manner as outlined in RFS Internal Operating Procedures V.E.7.a.

d. No one who is a candidate in the election being appealed may participate in the appeals process.

e. The Assembly's presiding officer and the preceding Governing Council at the Annual Meeting or the present Governing Council at the Interim Meeting will consider the appeals reports from the committee(s) dealing with the matter. Final decision on the election results will be the jurisdiction of the Governing Council as described above.

VI. RFS Sectional Delegates

A. Apportionment. The RFS is entitled to delegate and alternate delegate representation based on AMA Bylaw 2.4.2. This bylaw allots one delegate and one alternate delegate for each 2000 resident and fellow members of the AMA as recorded on December 31 of each year.

B. Eligibility.

1. All candidates for RFS Sectional Delegate or Alternate Delegate must be resident and fellow members of the AMA prior to campaigning or running for the position. Any resident and fellow member of the AMA is eligible to be nominated to be an RFS Sectional Delegate or Alternate Delegate. In order to enter his or her materials into the RFS handbook, a resident or fellow must obtain written endorsement from his or her constituent society or specialty organization prior to the posted deadline for printing handbook election materials. A candidate may be nominated from the floor of the Assembly as described in RFS Internal Operating Procedures V.B., but must subsequently obtain the endorsement of his or her constituent society or specialty organization within 30 days of his or her election. Should an elected RFS Sectional Delegate or Alternate Delegate not obtain endorsement within the allotted time, his or her election shall be null and void and the position shall be considered vacant.

2. Once candidates announce their endorsement, the endorsing constituent society or specialty organization may not be changed until a written statement of endorsement from the new endorsing society is provided to the RFS Governing Council. Each candidate is also required to provide a written

statement detailing how the candidate plans to ensure his or her attendance at the required meetings.

3. Cessation of Eligibility. If any Sectional Delegate or Alternate Delegate ceases to meet the membership requirements of AMA Bylaw 7.1.1 prior to the expiration of the term for which elected, the term of such Delegate shall terminate and the position shall be declared vacant. If the Delegate ceases to meet the membership requirements of the RFS within 90 days prior to an Annual Meeting, the Delegate shall be permitted to continue to serve in office until the completion of the Annual Meeting.

C. Duties and Privileges. RFS Sectional Delegates and Alternate Delegates shall be subject to the privileges and duties of all AMA delegates as outlined in the AMA Bylaws. They shall caucus with their endorsing society as well as assist the RFS Delegate and Alternate in representing the Resident and Fellow members of the AMA in the House of Delegates. RFS Sectional Delegates and Alternates shall not speak on behalf of the AMA-RFS unless first permitted to by the RFS Delegate or Alternate. They shall also be responsible for reporting back to the resident and fellow section of their state or specialty endorsing society regarding the activities of the AMA House of Delegates.

D. Seating. RFS Sectional Delegates shall be seated with their endorsing state or specialty society. In the case where a RFS Sectional Delegate has been endorsed by both his or her state and specialty society, he or she must choose, prior to his or her election, with which delegation he or she wishes to be seated. In the case of a vacant delegate seat, the RFS Delegate will appoint a RFS Sectional Alternate Delegate to fill that seat, taking into consideration the Sectional Delegate's state/region of the country and/or his or her specialty. The RFS Sectional Alternate Delegate will sit with the Sectional Delegate's endorsing society and vote with that endorsing society in place of the Sectional Delegate.

E. Limitations. There shall be a limit of one Sectional Delegate and one Sectional Alternate Delegate per state or specialty society. This limitation is intended to allow more than one candidate from a given state to be delegate so long as all those beyond the first shall be endorsed by and seated with his or her specialty delegation. This limitation is also intended to allow more than one candidate from a given specialty to be delegate so long as all those beyond the first shall be endorsed by and seated with his or her state delegation. It is highly encouraged that the membership takes into consideration geographic regions and specialties in order to encourage a broad representation of RFS Sectional Delegates in the AMA House of Delegates. These aforementioned limits shall be waived should their enforcement create vacancies in the position of Sectional Delegate or Alternate Delegate. None of these limits shall be construed to limit the number of residents or fellows who can be endorsed by any given state or specialty society.

F. Term of Sectional Delegates. The normal term shall commence with the close of the House of Delegates meeting that immediately follows his or her election and shall end at the close of the following Interim meeting of the House of Delegates.

G. Elections of Sectional Delegates.

1. Time of Election. The Sectional Delegates shall be elected at the Interim Meeting for a one-year term. The Governing Council shall set the day and hour of such elections and shall give the resident and fellow members of the Association ample notification.

2. Nominations. Nominations for Sectional Delegate shall be received in advance of the Interim Meeting, pursuant to the rules of the RFS. The Speaker shall allot time for further nominations to be made from the floor of the Business Meeting.

3. Campaigns. Each candidate shall be subject to the campaign rules in RFS Internal Operating Procedures V.D.

4. Voter Eligibility. A voter shall be defined as the RFS Assembly Delegate or Alternate Delegate who is credentialed at the time of the vote.

5. Method of Election. The voting system to be used in the RFS Sectional Delegate and Alternate Delegate elections will be an approval-based, plurality-at-large voting system.

    a. Voting Periods. The voting period for Sectional Delegates shall occur at the Interim Meeting at a time scheduled by the Speaker.

        i. Balloting. All nominees for the office of Sectional Delegate shall be listed on a single ballot with their endorsing society. The ballot will contain clear voting instructions with a brief explanation of ballot counting procedures. The voter must vote for exactly as many candidates as there are open positions. Ballots will be counted and delegates selected based on an approval-based, plurality-at-large voting system. Only nominees receiving a simple majority of the legal votes cast shall be elected. Ballots must be certified by the Speaker no more than 24 hours and no less than 1 hour prior to the election. The Speaker will allow all nominees to view the ballot and request changes to the ballot prior to the time of certification. Once the ballot is certified, no changes may be made. Candidates who receive written endorsement from their endorsing constituent association or specialty society prior to the election and provide a written statement detailing how they plan to ensure their attendance at the required meetings, will

have their names highlighted to clearly indicate that all of their endorsing materials were received prior to the election.

ii. Limitations. If there is more than one nominee from an endorsing state or specialty society, then only the nominee from that endorsing society who has a majority and who has the most votes shall be elected. All other nominees from that society shall be eliminated from the remaining counting of ballots. This process will continue throughout the counting of ballots to ensure that there is only one RFS Sectional Delegate per endorsing state and specialty society.

iii. Unfilled Seats/Runoff Elections. If there are unfilled Sectional Delegate seats after the election, a runoff election will be held between the remaining candidates receiving the most votes, with the exact number of candidates participating in the runoff to be determined by the formula 2n, inclusive of ties, where n equals the number of seats up for election, or the total number of remaining candidates, whichever is less. During the runoff election, the candidate(s) who receive(s) the highest number of votes, with a majority of legal votes cast, shall be elected. If any runoff election results in no seats being filled (due to no candidate achieving a majority), the candidate receiving the lowest number of votes shall be eliminated from balloting for the subsequent runoff election. This process will continue until all Sectional Delegate and Alternate Delegate seats are filled. If unfilled seats remain after elections are completed, one additional Sectional Delegate and Alternate Delegate per endorsing state/specialty society will be allowed in a subsequent balloting period. This process will continue through as many counting rounds as needed until all Sectional Delegate and Alternate Delegate seats are filled.

H. Elections of Sectional Alternate Delegates. Criteria and election procedures for Sectional Alternate Delegates shall be identical to those for Sectional Delegates except that the voting period shall follow the one for Sectional Delegates. All candidates for Sectional Delegate shall be eligible for Sectional Alternate Delegate.

I. Vacancies.

1. All delegate vacancies should be filled at the discretion of the Governing Council from among elected alternate delegates. If possible, the replacement delegate(s) should be selected from among alternate

delegates who are from the same society as the delegate that they are replacing.

2. Alternate Delegate vacancies should be solicited by the Governing Council via nominations open to all RFS members, and the Governing Council should select replacement Alternate Delegates from among those nominees through a majority vote of all Governing Council members present.

VII. Endorsement of Resident and Fellow Trustee

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

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

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

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

D. Endorsement Process.

1. Time. The endorsement of the Resident and Fellow Trustee shall occur during the voting period at the Interim Assembly Meeting of the AMA-RFS. The Governing Council shall set the day and time. Candidates may also be endorsed during the Annual meeting by rules outlined below.

2. Method of Endorsement. Where there is only one candidate, endorsement may be by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall be in order. Endorsements shall be by ballot. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no ranking, and it

should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed.

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

4. Validating. Upon completion of the tabulation, the Chair of the Rules Committee will validate the election results by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed and will then certify the results in writing. He or she will then immediately forward these results to the Assembly's presiding officer. Upon receipt of the Rules Committee's election results and verification, the presiding officer will announce the results to the Assembly.

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

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

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

VIII. Endorsement of Candidates for Elected AMA Councils

Ideally at least one eligible candidate for each resident/fellow position on elected AMA councils shall be endorsed by the RFS Assembly. These councils are: Council on Medical Service, Council on Medical Education, Council on Constitution and Bylaws, and Council on Science and Public Health. In order to be eligible for endorsement, a candidate must be an AMA member, be a resident or fellow during their term, and formally disclose to voters prior to the endorsement

election any portion of their term during which they will not be a resident or fellow. The AMA-RFS Assembly may endorse any, all, or none of the considered eligible candidates.

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

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

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

D. Endorsement Process.

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

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

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

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

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

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

IX. RFS Assembly Meeting

There shall be an Assembly meeting of resident and fellow members of the AMA-RFS held on a day prior to each meeting of the AMA House of Delegates.

A. Call to the Meeting. Ninety days prior to the meeting, notice shall be sent to all resident and fellows and resident and fellow organizations detailing the time, place, credentialing process, resolution mechanisms, election procedures, and education programs for the meeting.

B. Representatives to the Business Meeting from Organizations represented in the House of Delegates. The Business Meeting shall include representatives from constituent associations, Federal Services, national medical specialty societies, and professional interest medical associations represented in the House of Delegates.

1. Apportionment. The apportionment of each constituent association, Federal Service, national medical specialty society and professional interest medical associations is one representative for each 100, or fraction thereof, members of the Resident and Fellow Section who are members of the constituent association, Federal Service, national medical specialty society or professional interest medical association.

2. Effective Date. In January of each year, the AMA shall notify each constituent association, Federal Service, national medical specialty society and each professional interest medical association of the number of seats to which it is entitled. Such apportionment shall take effect on the following January 1 and remain effective for one year.

C. Other Representatives to the Business Meeting.

1. At-Large Representatives. Active resident/fellow physician members of the AMA may be eligible to serve as at-large representatives to the Resident and Fellow Section Business Meeting.

   a. Apportionment. The number of representatives shall be 10% of the average number of registered RFS delegates and alternate delegates from the previous year.

   b. Criteria for the At-Large Delegate positions include the following:
      A. All seats are self-funded;
      B. A candidate must be an AMA-RFS member;
      C. A candidate must submit an application to the RFS Governing Council for consideration; In the event that all available At-Large Positions are not filled by application to the Governing Council, these positions may be filled at the meeting (Annual or Interim) on a first-come, first served, basis.
      D. A candidate will be able to select whether to serve in this position for one meeting (Interim or Annual) or for an academic year;
      E. There are no term limits for these positions but candidates must reapply after each year;
      F. All vacant positions after Interim will be offered for Annual;
      G. Reasons for applying should include one of the following:
         i. First time attendee; or
         ii. Relocation due to a transition period; or
         iii. State or Specialty does not send representatives to the RFS Assembly or does not have an RFS Section; or
         iv. Candidate is a direct AMA member

2. National Resident and Fellow Organizations.

   a. Apportionment. Each national resident and fellow organization that has been approved for representation in the RFS Assembly may select one representative and one alternate representative.

   b. Criteria for Eligibility. National medical resident and fellow organizations that meet the following criteria may be considered for representation in the AMA Resident and Fellow Section Business Meeting:

      i. The organization must be national in scope.

ii. The organization must be composed solely of residents or fellows.

iii. Membership in the organization must be available to all residents or fellows, without discrimination.

iv. The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives.

v. The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.

c. Procedure. The organization must submit a written application containing sufficient information to establish that the organization meets the criteria described above. The application ideally should also include the following:

i. The organization's charter, constitution, bylaws and code of medical ethics.

ii. A list of the sources of the organization's financial support, other than the dues of its members.

iii. A list or description of all of the organization's affiliations.

iv. Such additional information as may be requested.

The Governing Council shall review the application. If it recommends that the organization be granted representation in the Resident and Fellow Section Business Meeting, the recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the organization may be represented in the Resident and Fellow Section Business Meeting.

d. Biennial Review Process. Each national resident and fellow organization represented in the Resident and Fellow Section Business Meeting must reconfirm biennially that it continues to meet the criteria for eligibility by submitting such information and documentation as may be required by the Governing Council.

e. Rights and Responsibilities. Representatives of national resident and fellow organizations in the Resident and Fellow Section Business Meeting shall have the following rights and responsibilities:

i. Full voting rights in the Business Meeting, except the right to vote in any elections, at the conclusion of a two-year probationary period with regular attendance.

ii. Presenting its policies and opinions in the Business Meeting.

iii. Reporting on the actions of the AMA Resident and Fellow Section.

iv. Cooperate in enhancing the AMA Resident and Fellow Section membership.

v. Ineligible for election to any office in the AMA Resident and Fellow Section.

f. Discontinuance of Representation. The Governing Council may recommend discontinuance of the representation by a national resident and fellow organization on the basis that the organization fails to meet the above criteria and responsibilities, or has failed to attend the Business Meeting of the AMA Resident and Fellow Section. The recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the representation of the national resident and fellow organization in the AMA Resident and Fellow Section Business Meeting shall be discontinued.

3. Official Observer. National resident and fellow organizations may apply to the AMA-RFS Governing Council for official observer status in the RFS Assembly. Applicants and official observers must demonstrate compliance with guidelines for official observers adopted by the AMA-RFS Assembly, and the Governing Council shall make a recommendation to the AMA-RFS assembly concerning the application. The AMA-RFS Assembly will make the final determination on the conferring or continuation of official observer status. Organizations with official observer status are invited to send one representative to observe the actions of the Assembly at all meetings of the RFS Assembly. Official observers have the right to speak and debate on the floor of the Assembly upon invitation from the Speaker. Official observers do not have the right to introduce business, introduce an amendment, make a motion, or vote.

D. Purposes of the Meeting. The purposes of the meeting shall be:

1. To hear such reports as may be appropriate.

2. To elect, at the Assembly meeting prior to the Annual meeting of the Association, the voting members of the Governing Council of the Resident and Fellow Section. To elect, at the Assembly meeting prior to the Interim meeting of the Association, the Chair-elect of the Governing Council of the Resident and Fellow Section, and to endorse the Resident and Fellow Trustee and councilor candidates.

3. To adopt resolutions for submission to the House of Delegates of the AMA.

4. To conduct such other business as may properly come before the meeting.

5. To provide programming to educate and provide value for members.

E. Credentialing. The name of the duly selected voting Assembly Delegates and Alternate Assembly Delegates from each state and specialty society should be received by the Director of Resident and Fellow Services of the AMA no later than 35 days prior to the assembly meeting in writing. On the day of the opening of the Assembly Meeting, credentialing will take place, where voting members must officially identify themselves to the Credentials Committee as having been duly selected to represent their state, specialty society or branch of the armed services.

F. Participation.

1. Only duly selected Assembly Delegates and Alternate Assembly Delegates to the assembly meeting shall have the right to vote, but the meeting floor, and right to testify, shall be open to all residents and fellow members of the AMA. The Presiding Officer of the Assembly may grant a non-RFS member the privilege of the floor.

2. The Immediate Past Chair of the AMA-RFS Governing Council, if he or she is no longer a resident or a fellow, shall have the same "speaking" privileges, excluding the privilege to make a motion, in the business meeting of the RFS Assembly as any other member of the Governing Council

G. Procedure.

1. Agenda. At least 21 days prior to the Assembly meetings, the agenda shall be sent to Assembly Delegates and Alternate Assembly Delegates. The order of business will be set by the Speakers prior to the meeting. The Assembly at any time may change the order of business by a majority vote.

2. Rules of Order. The Assembly meeting shall be conducted pursuant to the established rules of procedure submitted by the Speakers and adopted by the Assembly. The Rules of Order that govern the AMA House of Delegates shall govern the Assembly meeting of the RFS in all matters not outlined in the adopted rules of procedure mentioned above.

3. Quorum. Twenty percent of the registered Delegates shall constitute a quorum so long as at least 15 different states and 5 national medical specialty associations, military or federal agencies are represented.

H. Resolutions. Any resident and fellow member may submit resolutions.

1. All resolutions submitted by resident and fellows must be received in the AMA Department of Resident and Fellow Services 42 days prior to the Assembly meeting to be included in the Resident and Fellow Section agenda. They will be made available on the AMA website, and are debatable on the floor of the RFS Assembly.

2. Late Resolutions. Resolutions that are submitted after the 42-day deadline but 7 days prior to the Assembly meeting being called to order shall require a two-thirds vote of the Assembly to be debatable on the floor. The Rules Committee shall make recommendations to the Assembly on whether or not they should be considered as business. Late resolutions approved for consideration shall be referred to a reference committee, and handled in the same manner as those resolutions introduced before the 42-day deadline.

3. Emergency Resolutions. Resolutions that are submitted within 7 days of the meeting or after the meeting has been called to order shall require a three-fourths vote of the Assembly to be debatable on the floor. The Rules Committee shall make recommendations to the Assembly on whether or not they should be considered for business. Emergency resolutions approved for consideration shall be debated on the floor of the Assembly without referral to a reference committee.

4. All resolutions approved for consideration as business shall require a simple majority vote of the Assembly for adoption except those amending the IOP, which require a two-thirds vote as specified in RFS Internal Operating Procedures XIII.

5. Resolutions introduced by the Governing Council into the AMA Delegate's handbook shall be in the name of the RFS Delegate. Such resolutions may only be submitted when there is two-thirds approval by all voting members of the Governing Council. They shall be considered by the RFS Assembly as a first priority of business, and if not adopted or if

substantially amended, shall be withdrawn from the AMA House of Delegates.

6. Resolutions that are AMA policy proposals shall be submitted to the AMA House of Delegates in the name of the RFS at the first meeting to which they could be submitted in an appropriate and timely fashion following the closing of the AMA House of Delegates that is associated with the RFS Assembly at which they were approved unless otherwise specified by the RFS Assembly.

I. Convention Committees. The convention committees shall be, unless otherwise specified, appointed by the Governing Council. These committees are to expedite the conduct of business at each meeting of the RFS Assembly.

1. Credentials Committee. A 3- to 9- member Credentials Committee shall be composed, ideally, of one member per region as defined in RFS Internal Operating Procedures X.B and one Chair. The Committee shall be responsible for consideration of all matters relating to the registration and certification of delegates including credentialing delegates for business meetings, verifying a quorum is present, and distributing ballots for elections.

2. Logistics Committee. A Logistics Committee shall be composed of 3 to 5 At-Large members. The Committee shall be responsible for aiding the Assembly in performing those tasks to make the business of the Assembly most readily available to the Assembly. This shall include, but not be limited to, aiding with the use of computers to project amendments and actions for the Assembly's viewing, and for an Assembly delegate's ease.

3. Rules Committee. A Rules Committee shall be composed of 5 at-large members. The committee shall review late and emergency resolutions and make recommendations to the RFS Assembly on whether or not to consider them as business of the Assembly. The Rules Committee shall also be familiar with the Rules of Order such that they can assist residents throughout the business meeting. The Rules Committee shall also collect and tabulate ballots for RFS elections, and count hand votes during the business meeting as requested by the Speakers.

4. Reference Committees. The number and membership of reference committees appointed for each RFS Assembly meeting will be determined by the Speakers prior to each meeting. Each reference committee shall be composed of five members and one alternate unless, in the judgment of the Speakers, circumstances warrant an adjustment in the number of members on one or more reference committees. Each committee shall conduct an open hearing on items of business referred to it (resolutions and reports), and make recommendations to the Assembly for disposition

of its items of business through the preparation of reference committee reports for consideration by the RFS Assembly.

5. Hospitality Committee. A Hospitality Committee shall be composed of at least 3 members. This committee shall have the responsibility of aiding the Speakers and Governing Council in providing an as member-friendly experience as possible for attendees of the conference.

X. RFS Caucus of the AMA House of Delegates

A. RFS Caucus Structure.

1. The RFS sectional and alternate delegates, together with the RFS Delegate and Alternate, form the RFS Caucus.

2. The RFS Delegate and RFS Alternate Delegate should be considered the chair and vice chair of the caucus respectively and their responsibilities in those positions include, but are not limited to:

    a. Overseeing debate, discussion, and voting that occurs within the caucus, or designating a member of the caucus to fulfill this role if they are unable to perform it themselves.

    b. Assigning sectional and alternate delegates to reference committees.

    c. Speaking on behalf of the RFS in reference committee hearings and the HOD, or delegating the responsibility to speak on behalf of the RFS to other members of the section.

    d. Developing general RFS strategy for passing or defeating resolutions.

    e. Coordinating and negotiating with the leadership of other groups within the HOD.

3. Other resident and fellow delegates to the AMA HOD, including residents or fellows appointed to their state or specialty delegations, are not considered members of the caucus. They are encouraged to take part in RFS Caucus meetings and participate in discussions. If willing, they may still be assigned to speak on behalf of the RFS by the RFS Delegates.

B. Determining RFS Caucus Positions on AMA HOD Resolutions.

1. Determining RFS Caucus Positions on AMA HOD Resolutions

2. A quorum of at least 50% of voting members must participate for a vote to be valid.

3. In the AMA HOD, the RFS Caucus must take positions on resolutions that are consistent with the existing policy of the RFS as defined in the RFS Digest of Actions whenever possible.

4. In areas where relevant RFS policy exists, but the interpretation is uncertain, a majority vote of a quorum of delegates will determine the caucus's interpretation.

5. When a resolution is before the AMA HOD for which RFS policy does not exist, any member of the RFS Caucus may move that the RFS take a position on the resolution. Such a movement requires a second by another caucus member and a 2/3rds majority vote to pass.

6. Positions set using the procedures described in section B.5 are valid for the duration of that meeting only, and do not apply to future interim or annual meetings.

C. Reporting of Caucus Actions

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

XI. Regions

A. Purpose and Function.

1. The Regions shall exist to foster and promote AMA-RFS activities and membership on a regional level. The Regions shall function as a means of dissemination of RFS information, of recruitment to the RFS and of opportunity for involvement and leadership for RFS members regionally.

2. If any Regional Chair ceases to meet the membership requirements of AMA Bylaw 7.11 prior to the expiration of the term for which elected, the term of

such Regional Chair shall terminate and the position shall be declared vacant. If the Regional Chair ceases to meet the membership requirements of the RFS within 90 days prior to an Annual Meeting, the Region Chair shall be permitted to continue to serve in office until the completion of the Annual Meeting.

B. Regions Defined.

1. Region 1: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

2. Region 2: Illinois, Iowa, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Wisconsin

3. Region 3: Arkansas, Kansas, Louisiana, Mississippi, Oklahoma, Texas

4. Region 4: Alabama, Florida, Georgia, North Carolina, South Carolina, Tennessee

5. Region 5: Indiana, Kentucky, Michigan, Ohio, West Virginia

6. Region 6: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia

7. Region 7: Connecticut, New York, Maine, New Hampshire, Massachusetts, New Jersey, Rhode Island, Vermont

8. Region 8: National Specialty Societies, Military and Other Federal Agencies, All other societies not otherwise named herein.

C. Regional Governance.

1. Each Region shall be encouraged to author its own regional Internal Operating Procedures (IOP) that outline its mechanism of operation and governance. Any such Regional IOP shall supersede the procedures outlined within this section below, provided the regional IOP includes a Chair and has membership criteria identical to those written below or as otherwise approved by the RFS Governing Council.

2. Each Region shall abide by the operating procedures in this section unless they have adopted independent internal operating procedures:

   a. Membership.

i. A Person shall be considered a member of Region VIII if he or she is:

a) A Resident or Fellow member of the AMA.

b) A member of a national specialty medical society or is serving in the United States Army, the United States Navy, the United States Air Force, the United States Public Health Service, the Department of Veterans Affairs or other Federal agencies.

ii. A Person shall be considered a member of a Geographic Region (1-7) if he or she is:

a) A Resident or Fellow member of the AMA.

b) Serving in approved training programs or fellowship in a State in that Region, or, as his or her primary occupation, serving in a structured educational program begun immediately upon completion of medical school, residency or fellowship training in a State in that Region.

iii. Should any individual be a potential member of multiple regions due to educational, military, geographic and or specialty status, they must at the time of credentialing, identify their Regional affiliation. Neither an Assembly Delegate nor Assembly Alternate Delegate shall be a voting member for more than one region nor shall they be allowed to change their regional affiliation during a single year as defined as the beginning of an Annual meeting of the RFS Assembly until the opening of the following Annual meeting of the RFS Assembly. An individual shall be allowed to change affiliations from one geographic Region to another if they have moved from a residency or fellowship in one Region to one in another.

b. Regional Governance. Each Region shall, at each RFS Assembly Annual meeting, elect a Chair to serve a one-year term that begins at the conclusion of the concurrent meeting of the AMA House of Delegates (HOD) and that ends at the conclusion of the following meeting of the AMA-HOD. Election shall be by majority vote of AMA-RFS Assembly Delegates and Assembly

Alternate Delegates who are members of that Region. There shall be no votes by proxy.

c. Regional Activities.

i. Regions shall be encouraged to caucus on:

a) Reports/Resolutions.

b) Candidates (Including conducting AMA-RFS GC Candidate interviews).

c) Issues of importance to programs within the Region.

D. Regional Chairs.

1. Within their respective regions, Regional Chairs are responsible for the following:

a. Informing state leaders of current RFS events.

b. Increasing RFS membership.

c. Soliciting ideas of how to improve RFS activities.

d. Mobilizing RFS members for important AMA activities.

e. Promoting cooperation between local and national RFS leaders.

f. Developing new methods of how to increase resident/fellow participation in the RFS.

g. Coordinating and presiding over Regional Meetings.

2. At the Interim and Annual Meetings, the Regional Chairs are required to submit a short report of membership, legislative awareness, and leadership promotion activities to their respective regions and the RFS Governing Council.

3. Regional Chairs will also have an open invitation to all General Sessions of the AMA-RFS Governing Council and shall be invited to additional leadership events at the discretion of the AMA-RFS GC Chair.

E. Regional Council.

1. Purpose and Function. The Regional Council is designed to foster and promote strategic relationships between the RFS Governing Council, Regions, leaders of state and specialty society resident sections, and local residency/fellowship programs.

2. Membership. The Regional Council is comprised of eight regional chairs and the Member At-Large Officer from the RFS Governing Council, who shall serve as chair of the Regional Council.

3. Meetings. The Regional Council shall meet at least quarterly either in person or by teleconference in order to conduct the business of the Council.

XI. Appointments

It will be the responsibility of the RFS Governing Council to make appointments of the resident and fellow members of non-elected AMA Councils for confirmation by the AMA Board of Trustees or President-Elect as appropriate, and to other bodies of the Association when requested. It is also the responsibility of the Governing Council to make recommendations for resident and fellow representation to bodies such as the Residency Review Committees, National Board of Medical Examiners, National Residency Matching Program, and others after the Governing Council has solicited applications from interested resident and fellows.

A. Resident and Fellow Representation on AMA Councils.

1. At least one resident or fellow shall be recommended by the RFS Governing Council to the AMA president-elect for consideration for appointment to the Resident and Fellow seat on the Council on Ethical and Judicial Affairs.

2. At least one resident or fellow shall be recommended by the RFS Governing Council to the AMA Board of Trustees for consideration for appointment to the Resident and Fellow seat on the Council on Legislation.

3. At least one resident or fellow shall be recommended by the RFS Governing Council to the AMA Board of Trustees for consideration for appointment to the Resident and Fellow seat on the Council on Long Range Planning and Development.

4. At least one resident or fellow shall be recommended by the RFS Governing Council to the AMA Board of Trustees for consideration for

appointment to the Resident and Fellow seat on the Liaison Committee on Medical Education (an AMA/AAMC joint committee).

5. Terms. Residents and Fellows appointed to councils shall be in accordance with the AMA Bylaws. If the resident and fellow member of a Council ceases to be enrolled in an approved program for reason other than graduation, their service on the Council shall thereupon terminate and the position shall be declared vacant. If the resident or fellow ceases to be enrolled in an approved program due to graduation of that program, they may continue to hold their post for up to 90 days or until the completion of their term whichever comes first.

B. Standing Committees of the Resident and Fellow Section. The Governing Council shall annually appoint standing committees including, but not limited to, long range planning, public health, medical education, legislative awareness, membership and the poster symposium, composed of members of the Section to serve annual terms to further the mission of the Section. The Governing Council shall make an open solicitation of applications from the members of the section and shall select from among those who have applied. Should there be insufficient applications in order to adequately staff these committees, the Governing Council shall be empowered to make direct solicitations and appointments to the committees.

XII. Miscellaneous

A. Parliamentary Authority. The parliamentary authority of the AMA House of Delegates governs this organization in all parliamentary situations that are not provided for in the law or in the AMA Bylaws or adopted rules of the Resident and Fellow Section.

B. Financial Responsibility. Funding the RFS Governing Council is appropriated by the AMA. A listing of all meetings attended by each member of the Governing Council and members of AMA Councils, Committees, and Panels, along with an account of pertinent actions taken will be sent to RFS members semiannually.

XIII. Amendments

These Internal Operating Procedures may be amended by language proposed by the RFS Governing Council with the approval of two-thirds of the members of the Resident and Fellow Section Assembly present and voting. Where the Assembly instructs the Governing Council to script IOP changes, the language shall be submitted at the following Assembly meeting, unless otherwise specified, shall be considered at the business meeting and shall be effective immediately upon approval by two-thirds of the Assembly present and voting, unless a different time frame is so specified and approved by a simple majority when proposed. Amendments to

the Internal Operating Procedures may be contingent upon corresponding changes to the AMA Bylaws.

AMA-RFS POLICY RESOURCES

AMA-RFS 2018 Annual Meeting

LATE AND EMERGENCY RESOLUTION PROCEDURES

Late resolutions should be avoided whenever possible. The introduction of timely resolutions allows Assembly members time to research background information and AMA policy and prepare testimony either for or against a resolution. In addition, it gives Reference Committee members an opportunity to study background information in order to make an informed recommendation on the disposition of a resolution to the Assembly.

The submission of late resolutions was eliminated in 1989, due to the high referral/not adopt rate of resolutions that were introduced at the AMA-RFS Assembly Meetings. At the last two meetings prior to the elimination of late resolutions, seven of the eight late resolutions were not adopted or were referred to the Governing Council mainly due to a lack of basic factual information for both the Assembly and the Reference Committee members. The procedure for emergency resolutions was not eliminated.

However, the Assembly and Governing Council felt a need to have a mechanism to admit resolutions that have a legitimate reason for being late, while attempting to maintain an atmosphere of informed discussion of such resolutions. The following mechanisms must be used to introduce late and emergency resolutions.

For purposes of these rules, the following definitions will apply:

> **LATE RESOLUTIONS** - Resolutions that are submitted after the 42-day deadline but at least 7 days prior to the Assembly meeting being called to order shall require a two-thirds vote of the Assembly to be debatable on the floor. The Rules Committee shall make recommendations to the Assembly on whether or not they should be considered as business. Late resolutions approved for consideration shall be referred to a reference committee, and handled in the same manner as those resolutions introduced before the 42-day deadline.
>
> **EMERGENCY RESOLUTIONS** - Resolutions that are submitted within 7 days of the meeting or after the meeting has been called to order shall require a three-fourths vote of the Assembly to be debatable on the floor. The Rules Committee shall make recommendations to the Assembly on whether or not they should be considered for business. Emergency resolutions approved for consideration shall be debated on the floor of the Assembly without referral to a reference committee.

PROCEDURES

<u>Late Resolutions</u>

Late resolutions must be accompanied by a written statement addressing the following points:

- the timeliness/urgency of the resolution
- the importance of the resolution to the resident community
- why the resolution is being presented late

Copies of the resolutions will be available for members of the Assembly. In accordance with Parliamentary Procedure, limited debate will be allowed on acceptance of the resolutions only. Debate will not be allowed on the content of any of the resolutions. The author of each resolution will be given the opportunity to address the Assembly for one minute on the reasons to accept the resolution. Following

this limited debate, the Assembly should judge the merits of accepting the resolution on the three criteria listed above. The Assembly will then vote on whether to accept each resolution. A majority vote is required for acceptance.

Emergency Resolutions

The Rules Committee shall make recommendations to the Assembly on whether or not they should be considered for business. Emergency resolutions approved for consideration shall be debated on the floor of the Assembly without referral to a reference committee.

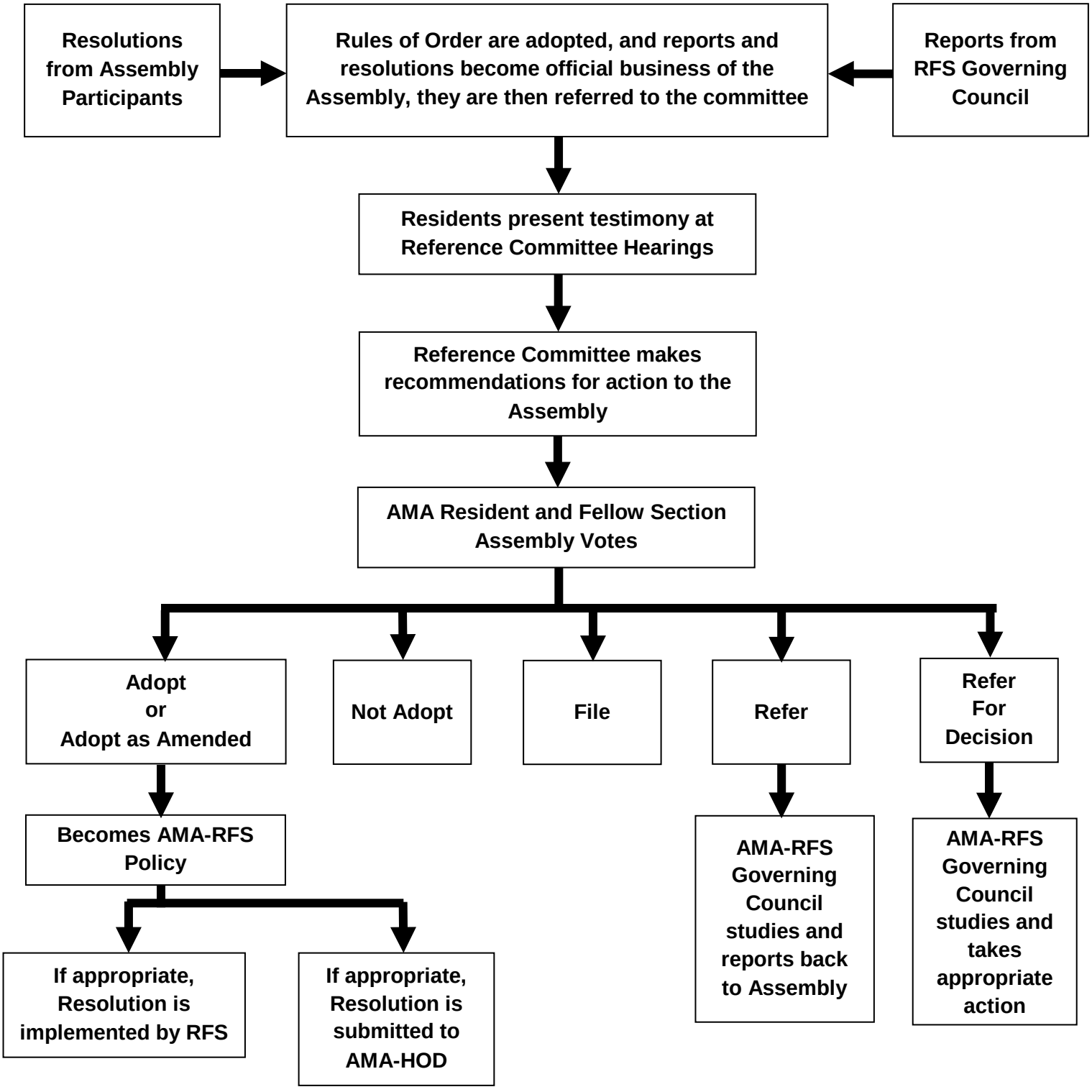
To accept an emergency resolution, the Assembly must suspend the AMA-RFS Rules of Order, which requires a three-fourths vote. To accept an emergency resolution it must be a true "emergency" issue which was not previously known to the Assembly and which must be dealt with immediately in order to have an impact. The mechanism for accepting these types of resolutions must be extremely difficult to prevent abuse of this system, and to ensure that only issues that are important and timely are heard by the Assembly.

Rules of Order: Debate Process

- A voting member or credentialed alternate voting member who wishes to speak on an issue pertaining to a particular resolution or report during the reference committee hearing should approach a microphone
- Once at the microphone, the voting member who wishes to speak should wait to be recognized, address the governing council speaker and give his or her name and affiliation before speaking on the issue.
- No one shall speak more than once on a single issue or separate motion until all who wish to speak have been heard, and no more than twice, without permission of the governing council speaker or upon a majority vote.
- Debate on an issue must be completed before another issue can be introduced.
- Debate is limited to 3 minutes per speaker. This limitation may be waived only by permission of the governing council speaker or a two-thirds vote.
- Overall debate on any single issue is limited to no more than 15 minutes, provided both sides have been represented, unless given permission by the governing council speaker or a two-thirds vote.
- Any amendments more than 3 words long must be presented to the secretary, in writing, before being discussed at the meeting.
- Voting shall be by voice and/or a showing of hands. However, if a vote is unclear, the governing council speaker or a voting member can call for a “division” and votes will be counted.

Effective April 1993
Revised January 2017

Policy Development Process



BASIC RULES

Order of precedence[1]	*Can interrupt?*	*Requires a second?*	*Debatable*	*Amendable?*
PRIVILEGED MOTIONS				
1. Adjourn	No	Yes	Yes[2]	Yes[2]
2. Recess	No	Yes	Yes[2]	Yes[2]
3. Question of privilege	Yes	No	No	No
SUBSIDIARY MOTIONS				
4. Table	No	Yes	No	No
5. Close debate	No	Yes	No	No
6. Limit or Extend debate	No	Yes	Yes[2]	Yes[2]
7. Postpone to a certain time	No	Yes	Yes[2]	Yes[2]
8. Refer to committee	No	Yes	Yes[2]	Yes[2]
9. Amend	No	Yes	Yes[3]	Yes
MAIN MOTIONS				
10. a. The main motion	No	Yes	Yes	Yes
b. Specific main motions				
Adopt in-lieu-of	No	Yes	Yes	Yes
Amend a previous action	No	Yes	Yes	Yes
Ratify	No	Yes	Yes	Yes
Recall from committee	No	Yes	Yes[2]	No
Reconsider	Yes[4]	Yes	Yes[2]	No
Rescind	No	Yes	Yes	No

INCIDENTAL

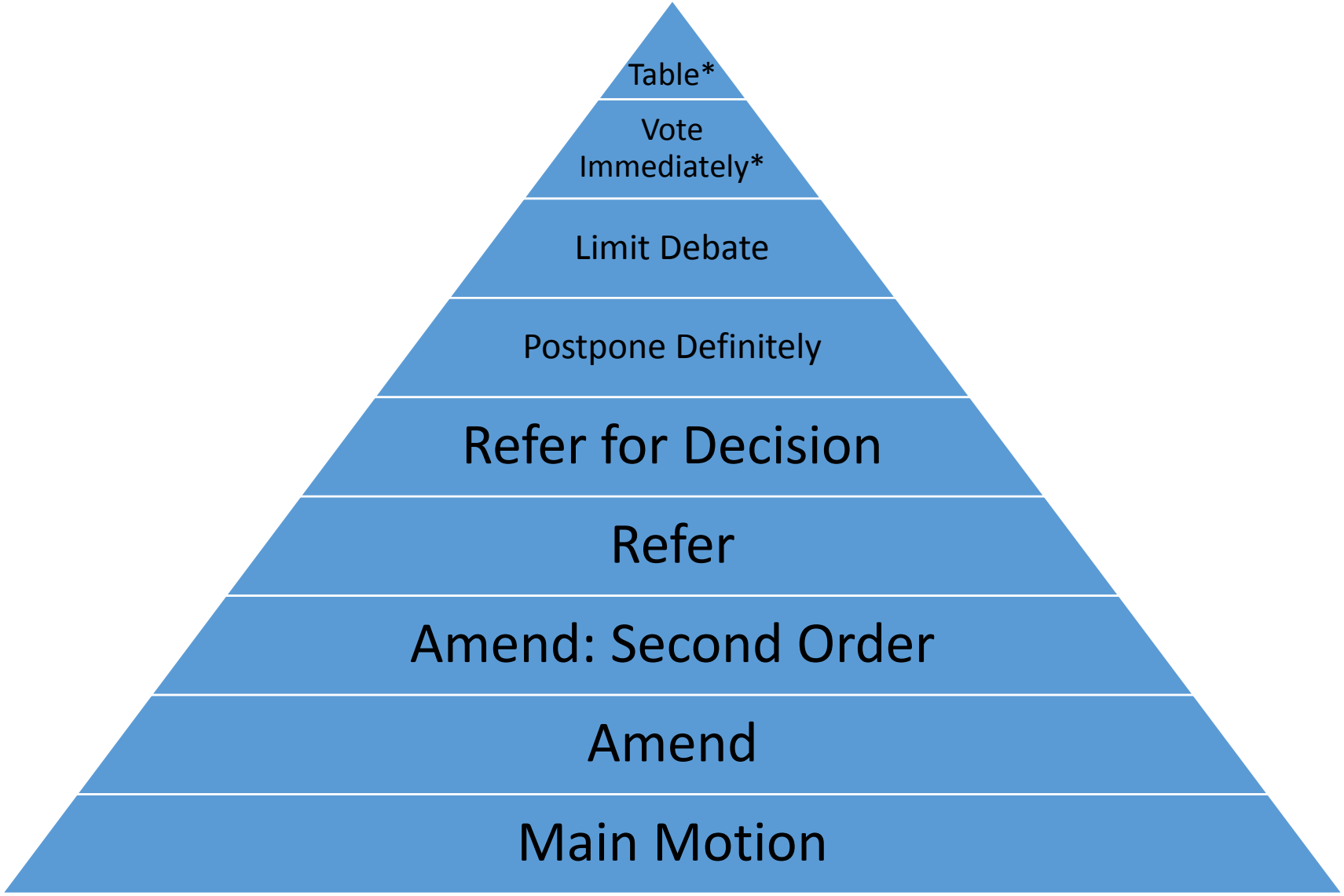
No order of precedence	*Can interrupt?*	*Requires a second?*	*Debatable?*	*Amendable?*
MOTIONS				
Appeal	Yes	Yes	Yes	No
Suspend the rules	No	Yes	No	No
Consider informally	No	Yes	No	No
REQUESTS				
Point of order	Yes	No	No	No
Inquiries	Yes	No	No	No
Withdraw a motion	Yes	No	No	No
Division of question	No	No	No	No
Division of assembly	Yes	No	No	No

[1] Motions are in order only if no motion higher on the list is pending. Thus if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.

[2] Restricted.

[3] Is not debatable when applied to an undebatable motion.

[4] A member may interrupt the proceedings but not a speaker.



* Not Debatable

Important Points About Amendments

1. A primary amendment amends the pending motion and must be germane (closely related) to the main motion.

2. A secondary amendment amends the primary amendment and must be germane to the primary amendment.

3. There may be only one primary and one secondary amendment pending at the same time to the same motion.

4. A motion to amend by substitution is a motion to strike out a paragraph or a main motion of only one sentence, and to insert a different paragraph or main motion.

5. An amendment by substitution is a primary amendment.

6. The paragraph to be struck out is opened to amendment first by any of the three methods of amending: *to insert or to add; to strike out;* or *to strike out and insert.* The paragraph to be inserted is then opened to amendment by any of the three methods of amending. These are secondary amendments and only one can be proposed at a time.

7. If the motion to substitute is adopted, the substitute motion replaces the main motion, thereby becoming the main motion. It may then be amended only by adding (at the end) wording which does not change the intent. Furthermore, the substituted motion now "the main motion as amended", must be put to a vote in order to secure final approval by the members.

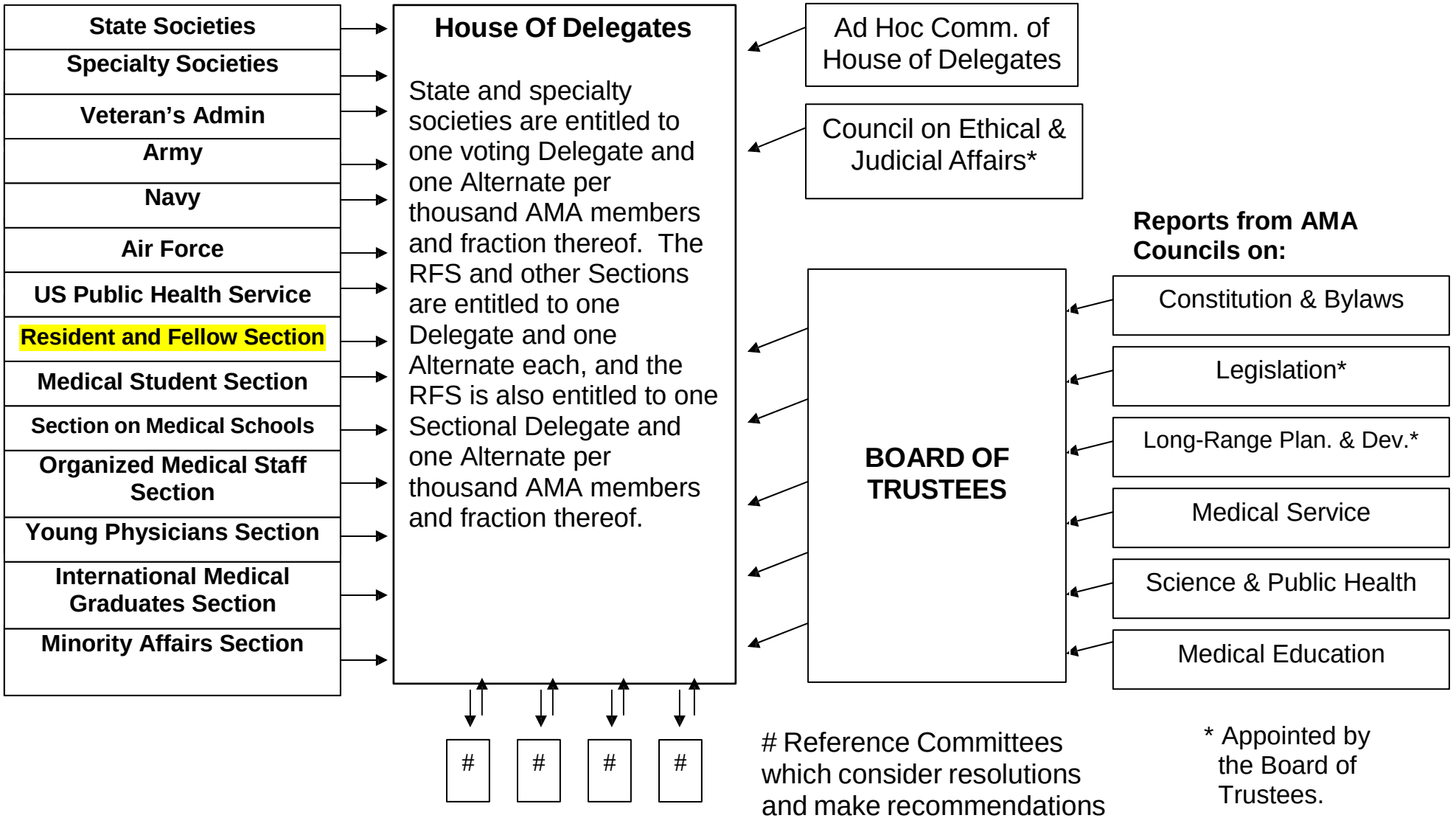
8. If the motion to substitute is not adopted, it is given no further consideration and debate returns to the original main motion (as or as not amended).

Prepared by Avis McDonald, PRP

How AMA Sets Policy

Resolutions From Delegates Representing:

Input into the Meetings of the AMA House of Delegates



Reference Committees which consider resolutions and make recommendations to the House.

* Appointed by the Board of Trustees.