2019 AMA International Medical Graduates Section Interim Meeting
Manchester Grand Hyatt, San Diego
November 15-19, 2019

.

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AMA
AMERICAN MEDICAL ASSOCIATION

Professional.

Ethical.

Welcoming.

Safe.

This is what we expect of our members and guests at AMA-sponsored events.

All attendees are expected to exhibit respectful, professional and collegial behavior consistent with the Code of Conduct passed by the AMA House of Delegates.

We take claims of harassment and conflicts of interest seriously. Visit **ama-assn.org/codeofconduct** to learn more. Violations of the Code of Conduct may be reported as follows:

- Conduct liaison assigned to the meeting
- AMA Office of General Counsel
- AMA speaker or vice speaker
- Our third-party hotline at (800) 398-1496 or online at lighthouse-services.com/ama (which includes an anonymous reporting option)

AMA International Medical Graduates Section Meeting Schedule

2019 Interim Meeting

Manchester Grand Hyatt – San Diego

November 15-19, 2019

(business casual attire unless seated in front of Dais during HOD)

Friday, November 15		
7:00 a.m.- 6:00 p.m.	**House of Delegates registration**	Hyatt, 2nd level, Palm Foyer
1:00–6:00 p.m.	AMA Research Symposium/Expo (MSS, RFS, IMGS) Events (for your information)	Hyatt Grand Hall C-D, Lobby level
2:00-3:00 p.m.	Educational session: "**Seeking mental health care as physicians and future physicians"**	Marina D, Marriott
1:00-2:00 p.m.	Research Symposium Participant Check-in/Set-up	Grand Hall C-D, Lobby Level
2:00-3:30 p.m.	Judge check-in	"
3:00-6:00 p.m.	Poster showcase	"
4:00-6:00 p.m.	Poster presentation competition and judging	"
7:00-7:30 p.m.	Announcement of 2019 AMA EXPO Research Symposium winners	"
	AMA CAREER FAIR	"
12:00 – 1:00 p.m.	AMA Career Fair Exhibit Set-Up	"
1:00-5:00 p.m.	Career Fair and general exhibitors	"

Saturday, November 16		
7:00 a.m. -6:00 p.m.	House of Delegates registration	Hyatt, 2nd level, Palm Foyer
9:00-9:45 a.m.	Sections and Special Groups Advocacy Session, "Amplify your voice: How physicians can shape health policy"	Hyatt, Harbor G-H
9:00 a.m.	**IMGS Late Resolutions Due –** send to img@ama-assn.org	
2:00-6:00 p.m.	House of Delegates Opening	Seaport Ballroom, 2nd level
5:00-7:00 p.m.	**IMGS Congress Business Meeting** Guest Speaker: Todd Askew, AMA Senior Vice President, Advocacy – "Addressing the Challenge of Equitable Drug Pricing in the Era of Precision Medicine" **Accreditation Statement:** The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. **Designation Statement:** The AMA designates this live activity for a maximum of 0.75 *AMA PRA Category 1 Credit™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity.	Harbor B, 2nd level
7:00-8:30 p.m.	**Joint Women Physicians/ IMG Sections Reception**	Harbor A, 2nd level
Sunday, November 17		
7:00 a.m. – 4:00 p.m.	House of Delegates registration	Hyatt, 2nd level, Palm Foyer
8:00–8:30 a.m.	House of Delegates Opening (consent calendar/extractions)	Seaport Ballroom, Level 2
8:30 a.m.– noon	**Reference Committee Hearings** Amendments to Constitution and Bylaws Reference Committee B (Legislation/health reform) Reference Committee C (Medical Education) Reference Committee F (Finance & Governance) Reference Committee J (Advocacy on medical service, medical practice, insurance, et.al.)	Grand Hall C, lobby level Harbor G-I, 2nd level Harbor A-C, 2nd level Seaport Ballroom-2 Harbor D-F, 2nd level

	Reference Committee K (Advocacy related to, science and public health)	Grand Hall D, lobby level
2:30-3:30 p.m.	**IMGS Busharat Ahmad, MD Leadership Development Program** Guest speaker: Colonel Arthur Athens, "Back to the Basics: the Fundamentals of Extraordinary Leadership" **Accreditation Statement:** The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. **Designation Statement:** The AMA designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit™.* Physicians should claim only the credit commensurate with the extent of their participation in the activity.	Coronado D, 4th level
3:00-5:00 p.m.	HOD Educational Sessions	*Various (See APP schedule)*
Monday, November 18		
7:00 a.m. – 6:00 p.m.	House of Delegates registration	Hyatt, 2nd level, Palm Foyer
8:00 –11:00 a.m.	Educational Sessions	Various - (Check app or monitors)
9:00-10:00 a.m.	**IMG & Minority Affairs Sections Delegates Caucus**	City View A/B, 32nd floor
2:00–6:00 p.m.	House of Delegates Business Session	Seaport Ballroom, Level 2
8:00 –11:00 a.m.	Educational Sessions	Various - (Check app or monitors)
Tuesday, November 19		
7:00 a.m. – noon	House of Delegates registration	Hyatt, 2nd level, Palm Foyer
8:30 a.m.–noon	House of Delegates Business Session	Seaport Ballroom, Level 2

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Meeting Logistics

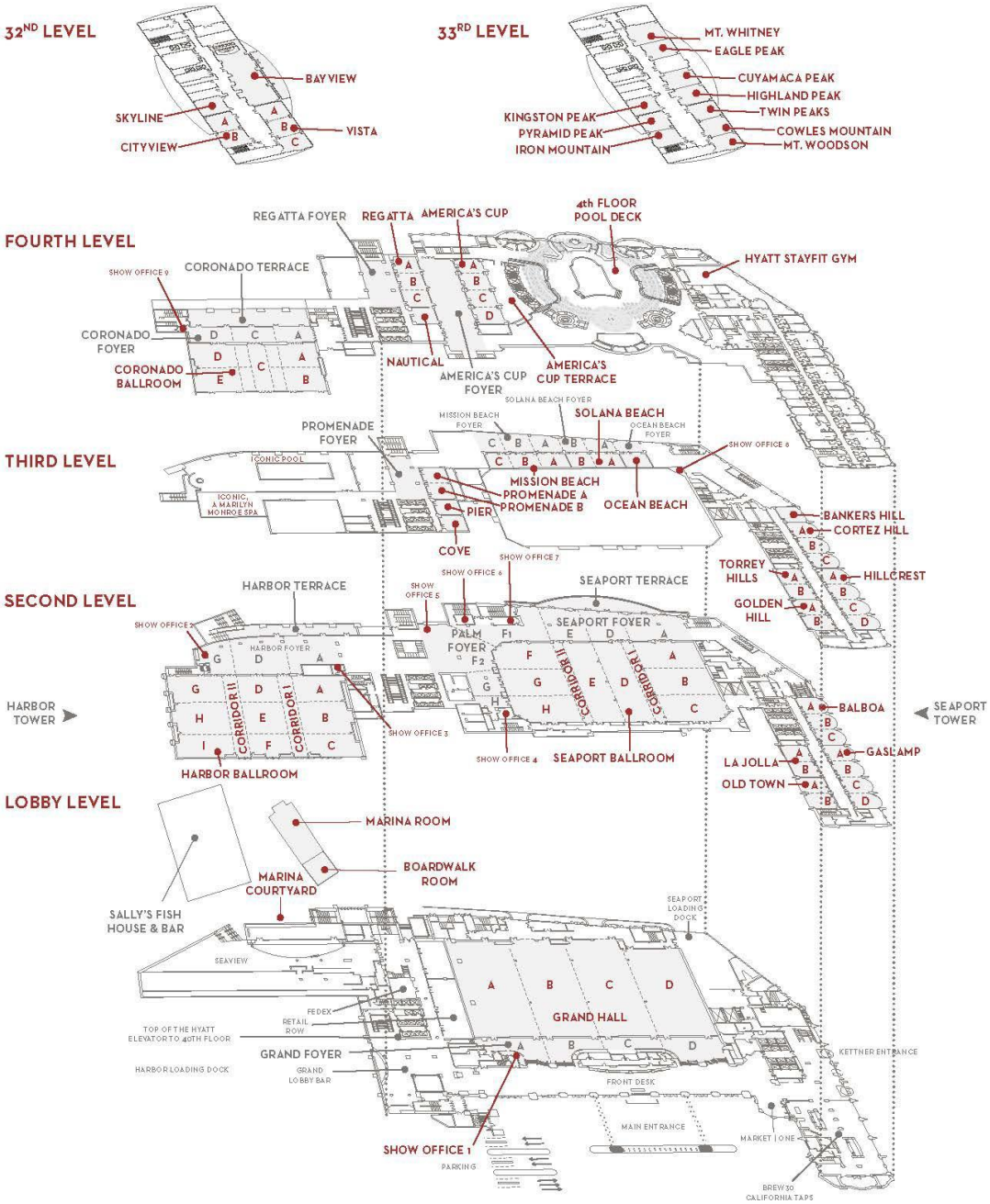
Wi-Fi: 2019INTERIM Password: 2019INTERIM
Manchester Grand Hyatt hotel map Marriott Marquis hotel map
Meeting app information

For the best user experience, please download a copy of this handbook to your personal device

Manchester Grand Hyatt

FLOOR PLAN

All Floors



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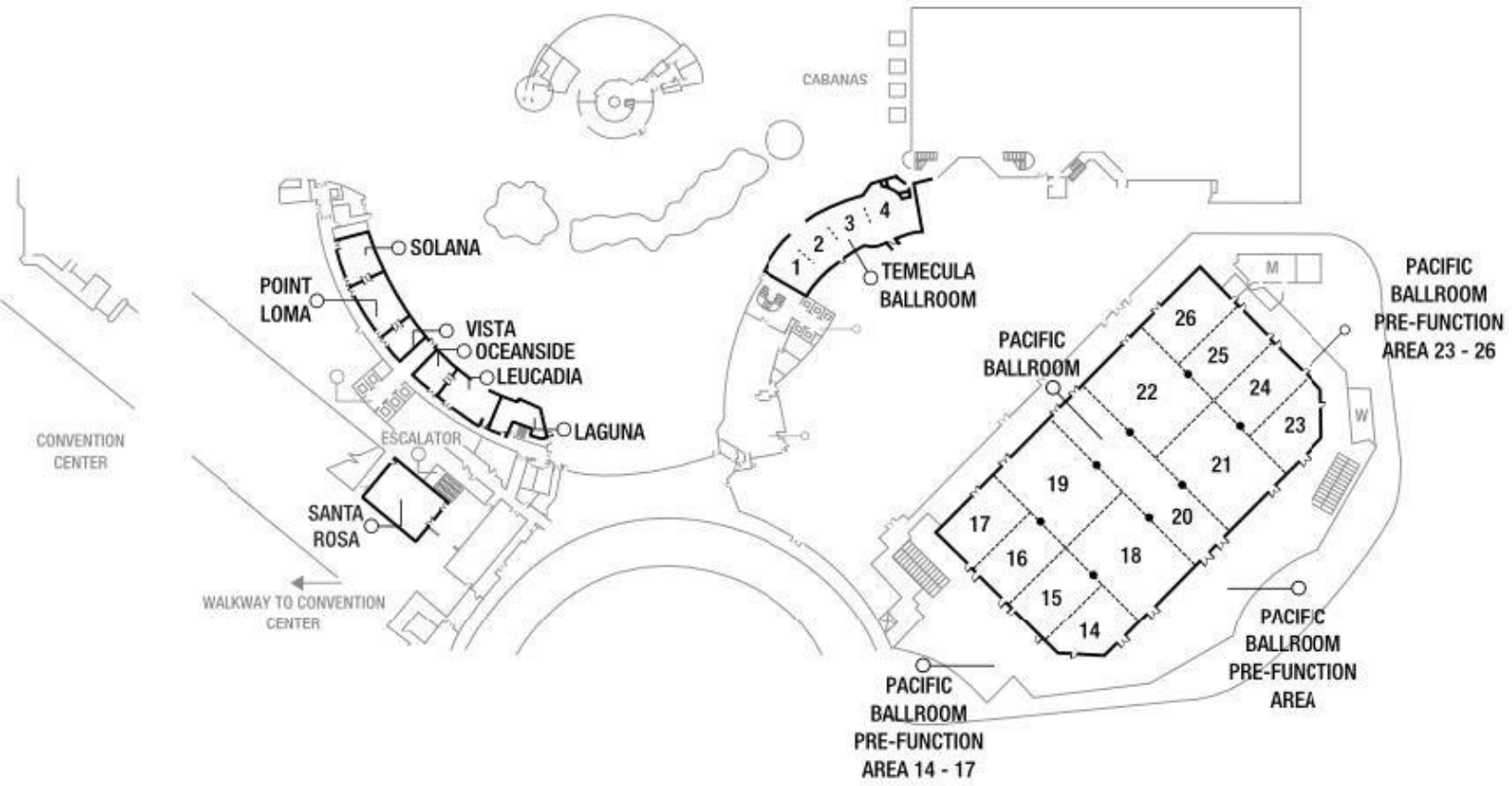
Marriott Marquis
Level One



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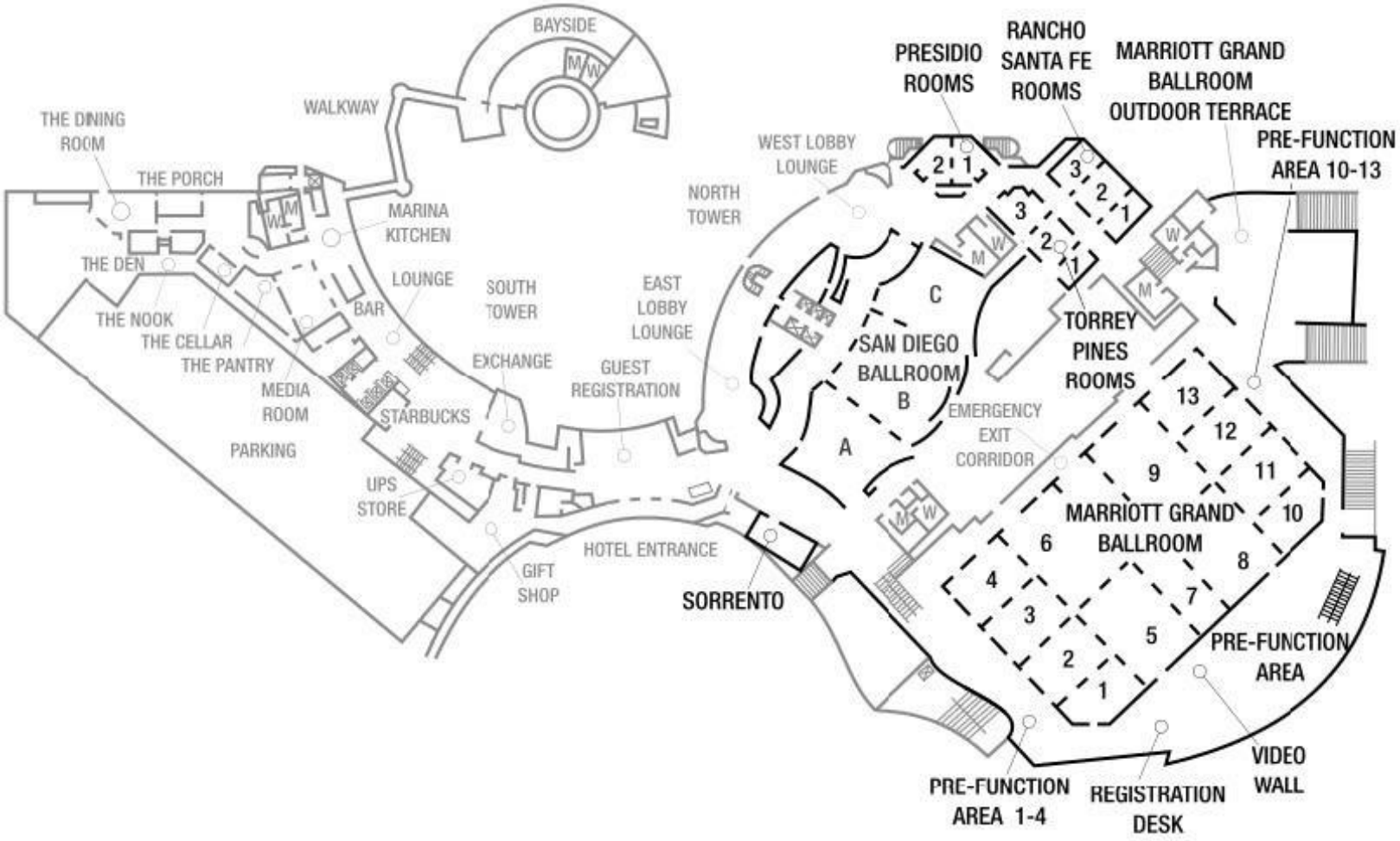
Marriott Marquis
Lobby Level



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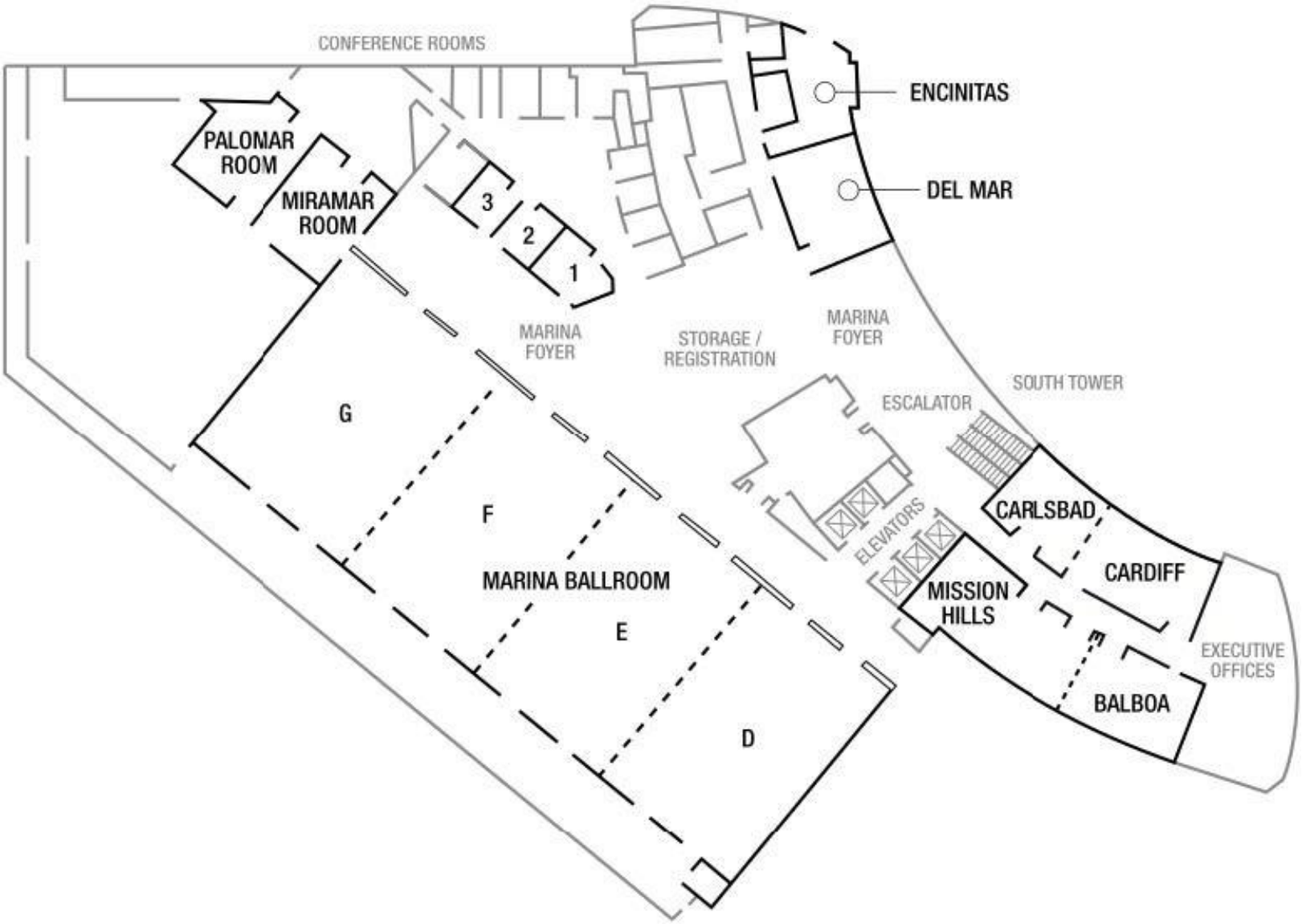
Marriott Marquis
South Tower - Level 3



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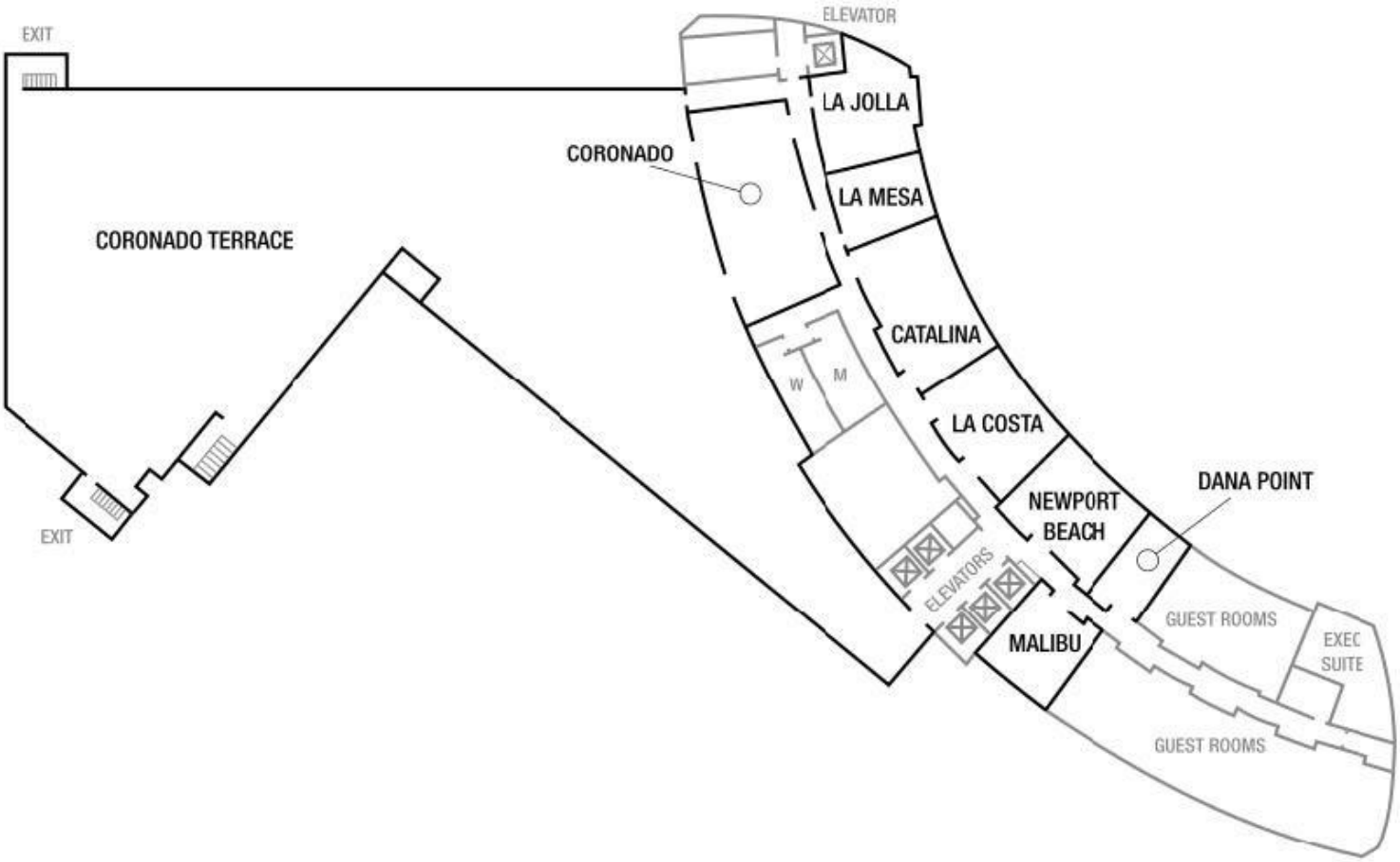
Marriott Marquis
South Tower - Level 4



For the best user experience, please download a copy of this handbook to your personal device

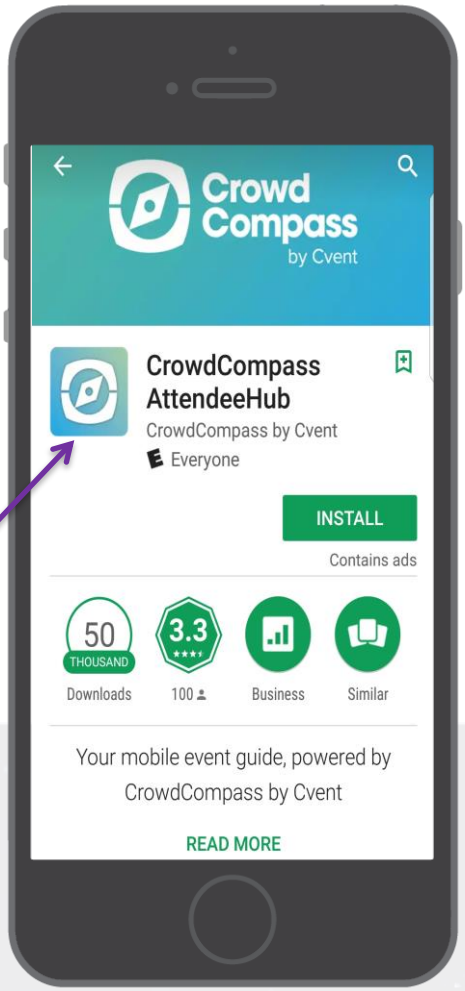
Downloading the App

Get the app

1. Go to the right store. Access the App Store on iOS devices and the Play Store on Android.

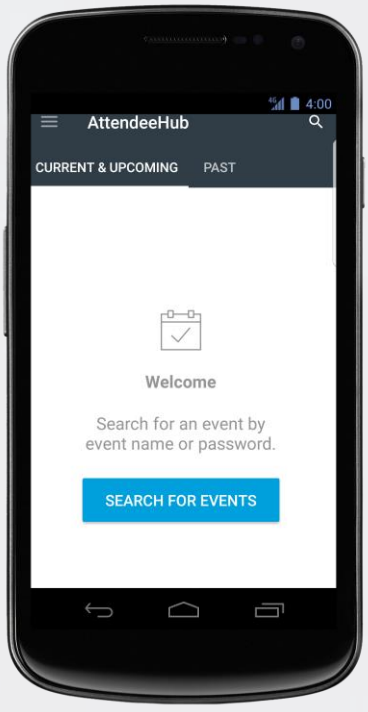
If you're using a Blackberry or Windows phone, skip these steps. **You'll need to use the web version of the app found here:**
https://event.crowdcompass.com/amainterim19

or Scan here for online version



2. Install the app. Search for CrowdCompass AttendeeHub Once you've found the app, tap either **Download** or **Install**.

After installing, a new icon will appear on the home screen.



Find your event

1. Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter
AMA 2019 Interim Meeting
2. Open your event. Tap the name of your event to open it.

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The "CrowdCompassAttendeeHub" Mobile App - FAQ

Where can I download the mobile app?

Go to the correct store for your device type. Access the App Store on iOS devices and the Play Store on Android.

Install the app. Search for CrowdCompassAttendeeHub. Once you have found the app, tap either Download or Install. After installing, a new icon will appear on your home screen.

AttendeeHub

If you're using a Blackberry or Windows phone, skip these steps. You'll need to use the web version of the app found here https://event.crowdcompass.com/amaannual2019

How do I find the Event?

Search the AttendeeHub. Once downloaded, open the AttendeeHub app and enter: AMA 2019 Annual Meeting

The app is asking me to log in. Why do I need to log-in?

Once you log in to the mobile app, you will be able to access the same schedules, bookmarks, reminders, notes, and contacts on your phone, tablet, and desktop. Below is a list of some other great things you can do after logging in:

- Take notes
- Share photos
- Rate sessions
- Join the attendee list
- Check-in
- Share contacts
- Share over social media
- Take Surveys
- Message fellow attendees

Where can I get my log-in information?

The log-in process is largely self-managed. Just follow the steps below to log in from your device:

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next. Enter an email address, and then tap next again.

3. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

I've requested log-in information, but I never received an email.

If you haven't received your log-in information, one likely culprit may be your spam filter. We try to tailor our email communications to avoid this filter, but some emails end up there anyway. Please first check the spam folder of your email. The sender may be listed as CrowdCompass.

I lost my log-in info, and I forgot my confirmation code. How do I log myself back in?

To have a verification email resent to you, start by accessing the sign-in page.

1. **Access the Sign In page:** Tap the hamburger icon in the upper-left corner to open the side nav, then Log In.

2. **Enter your info:** You'll be prompted to enter your first and last name. Tap Next.

3. **Click on Forgot Code:** If you've already logged in before, the app will already know your email address and will send a verification email to you again.

4. **Verify your account:** A verification email will be sent to your inbox. Open it and tap Verify Account. You'll see your confirmation code has already been carried over. Just tap Finish. You'll be taken back to the Event Guide with all those features unlocked.

How do I create my own schedule?

1. **Open the Schedule.** After logging in, tap the Schedule icon.

2. **Browse the Calendar.** Switch days by using the date selector at the top of the screen. Scroll up and down to see all the sessions on a particular day.

3. **See something interesting?** Tap the plus sign to the right of its name to add it to your personal schedule.

How can I export my schedule to my device's calendar?

1. **Access your schedule.** After logging in, tap the hamburger icon in the top right, then My Schedule.

2. Here you'll see a personalized calendar of the sessions you'll be attending. You can tap a session to see more details.

3. **Export it.** Tap the download icon at the top right of the screen. A confirmation screen will appear. Tap Export and your schedule will be added directly to your device's calendar.

How do I allow notifications on my device?

Allowing Notifications on iOS:

1. **Access the Notifications menu.** From the home screen, tap Settings, then Notifications.

2. **Turn on Notifications for the app.** Find your event's app on the list and tap its name. Switch Allow Notifications on.

Allowing Notifications on Android:

Note: Not all Android phones are the same. The directions below walk you through the most common OS, Android 5.0.

1. **Access the Notification menu.** Swipe down on the home screen, then click the gear in the top right. Tap Sounds and notifications.

2. **Turn on Notifications for your event's App.** Scroll down and tap App notifications. Find your event's app on the list. Switch notifications from off to on.

How do I manage my privacy within the app?

Set Your Profile to Private…

1. **Access your profile settings.** If you'd rather have control over who can see your profile, you can set it to private.

2. After logging in, tap the hamburger icon in the top left, and then tap your name at the top of the screen.

3. **Check the box.** At the top of your Profile Settings, make sure that the box next to "Set Profile to Private" is checked.

…Or Hide Your Profile Entirely

1. **Access the Attendee List.** Rather focus on the conference? Log in, open the Event Directory, and tap the Attendees icon.

2. **Change your Attendee Options.** Click the Silhouette icon in the top right to open Attendee Options.

3. **Make sure the slider next to "Show Me On Attendee List" is switched off.** Fellow attendees will no longer be able to find you on the list at all.

How do I message other attendees within the app?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send your message.** Find the person you want to message by either scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon to start texting.

3. **Find previous chats.** If you want to pick up a chat you previously started, tap the hamburger icon in the top right, then **My Messages**.

How do I block a person from chatting with me?

1. **Access the Attendee List.** Rather focus on the conference? Just as before, log in and tap the Attendees icon.

2. **Block the person.** Find the person you'd like to block about by scrolling through the list or using the search bar at the top of the screen. Tap their name, then the chat icon. But, don't type anything, instead tap Block in the top right.

I want to network with other attendees. How do I share my contact info with them?

1. **Access the Attendee List.** After logging in, tap the Attendees icon.

2. **Send a request.** Find the person you want to share your contact information by either scrolling through the list or using the search bar at the top of the screen.

3. Tap their name, then the plus icon to send a contact request. If they accept, the two of you will exchange info.

I want to schedule an appointment with other attendees. How do I do that?

1. **Navigate to My Schedule.** Tap the hamburger icon in the top left, then My Schedule.

2. **Create Your Appointment.** In the top right corner of the My Schedule page you'll see a plus sign. Tap on it to access the Add Activity page.

3. **Give your appointment a name, a start and end time, and some invitees.** When you're finished, tap done. Invitations will be immediately sent to all relevant attendees.

How do I take notes within the app?

Write Your Thoughts...

1. **Find your Event Item.** After logging in, find the session, speaker, or attendee you'd like to create a note about by tapping on the appropriate icon in the Event Directory, then scrolling through the item list. Once you've found the item you're looking for, tap on it.

2. **Write your note.** Tap the pencil icon to bring up a blank page and your keyboard. Enter your thoughts, observations, and ideas. Tap done when you've finished.

…Then Export Them

1. **Navigate to My Notes.** Tap the hamburger icon in the top right, then My Notes. Here you'll find all the notes you've taken organized by session.

2. **Choose where to send your notes.** Tap the share icon in the top right and CrowdCompass will automatically generate a draft of an email that contains all your notes. All you have to do is enter an email address, and then tap Send.

Meeting Guidelines

Parliamentary Procedure Rules
Rules of Order
Resolution Writing Guide

American Institute of Parliamentarians Standard Code of Parliamentary Procedure

Basic Rules Governing Motions

Order of Rank/Precedence[1]	Interrupt	Second	Debate	Amend	Vote	Applies to what other motions?	Can have other motions applied?[5]	Renewable
Privileged Motions								
1. Adjourn	No	Yes	Yes[2]	Yes[2]	Majority	None	Amend, Close Debate, Limit Debate	Yes
2. Recess	No	Yes	Yes[2]	Yes[2]	Majority	None	Amend, Close Debate, Limit Debate	Yes[6]
3. Question of Privilege	Yes	No	No	No	None	None	None	Yes
Subsidiary Motions								
4. Table	No	Yes	No	No	2/3	Main Motion	None	No
5. Close Debate	No	Yes	No	No	2/3	Debatable Motions	None	Yes
6. Limit Debate	No	Yes	Yes[2]	Yes[2]	2/3	Debatable Motions	Amend, Close Debate	Yes[6]
7. Postpone to a Certain Time	No	Yes	Yes[2]	Yes[2]	Majority	Main Motion	Amend, Close Debate, Limit Debate	Yes[6]
8. Refer to Committee (or Board)	No	Yes	Yes[2]	Yes[2]	Majority	Main Motion	Amend, Close Debate, Limit Debate	Yes[6]
9. Amend	No	Yes	Yes[3]	Yes	Majority	Rewordable Motions	Close Debate, Limit Debate	No[6]
Main Motions								
10a. The Main Motion	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
10b. Specific Main Motions								
Adopt in-lieu-of	No	Yes	Yes	Yes	Majority	None	Subsidiary	No
Amend a Previous Action	No	Yes	Yes	Yes	Same Vote	Adopted MM	Subsidiary	No
Ratify	No	Yes	Yes	Yes	Same Vote	Adopted MM	Subsidiary	No
Recall from Committee	No	Yes	Yes[2]	No	Majority	Referred MM	Close/Limit Debate	No
Reconsider	Yes[4]	Yes	Yes[2]	No	Majority	Vote on MM	Close/Limit Debate	No
Rescind	No	Yes	Yes	No	Same Vote	Adopted MM	Subsidiary; *not* amend	No

American Institute of Parliamentarians Standard Code of Parliamentary Procedure Motions Table

Incidental Motions (non-ranking within the classification)								
Motions								
No order of Rank/Precedence	**Interrupt**	**Second**	**Debate**	**Amend**	**Vote**	**Applies to what other motions?**	**Can have other motions applied?**	**Renewable**
Appeal	Yes	Yes	Yes	No	Majority[7]	Ruling of Chair	Close/limit debate	No
Suspend the Rules	No	Yes	No	No	2/3	Procedural Rules	None	Yes
Consider Informally	No	Yes	No	No	Majority	Main Motion or Subject	None	Yes
Requests								
Point of Order	Yes	No	No	No	None	Procedural error	None	No
Inquiries	Yes	No	No	No	None	All motions	None	No
Withdraw a Motion	Yes	No	No	No	None[8]	All motions	None	No
Division of a Question	No	No	No	No	None[8]	Main Motion	None	No
Division of Assembly	Yes	No	No	No	None[8]	Indecisive Vote	None	No

MM = Main Motion

[1]Motions are in order only if no motion higher on the list is pending.
[2]Restricted
[3]Not debatable when applied to undebatable motion
[4]Member may interrupt proceedings, but not a speaker
[5]Withdraw may be applied to all motions
[6]Renewable at discretion of presiding officer (chair)
[7]Tie or majority vote sustains the ruling of the presiding officer; majority vote in negative reverses the ruling
[8]If decided by assembly (by motion), requires a majority vote to adopt

American Institute of Parliamentarians
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www.aipparl.org
aip@aipparl.org

☐ Resolution† submitted by:

_____
(name of state, specialty, section or individual delegate)

☐ Subject:

_____
(the title of the resolution should appropriately and concisely reflect the action for which it calls)

☐ Whereas statement(s) is (are) included - or- ☐ Whereas statements not necessary

Whereas statements support / provide background to establish the intent of the RESOLVED clauses. You may include as many whereas statements as necessary to provide the foundation for the RESOLVED statements.

☐ RESOLVED statement(s) is (are) included (if not, is this an information statement, see below)

RESOLVED statements are requests for the AMA to take a specific position or course of action to address the concern(s) expressed in the whereas statement(s). The House acts only the RESOLVED portions of resolutions. Each RESOLVED statement must be accompanied by one of the following identifiers indicating the nature and purpose of the proposed RESOLVED:

- New HOD Policy[1]
- Reaffirm HOD Policy[3]
- Consolidate Existing Policy
- Rescind HOD Policy
- Modify Bylaws
- Modify Current HOD Policy[2]
- Directive to Take Action[4]

☐ Each RESOLVED statement is focused, stands alone (without reference to whereas statements or other resolves), and provides a specific, clear direction or action required by the AMA should it be adopted.

☐ Resolution includes a list of existing policy related to the subject. (The latest edition of PolicyFinder is available online or for download at ama-assn.org/go/policyfinder.)

☐ To the extent possible, each RESOLVED makes adjustments, additions or elaborations to existing policy rather than creating new, possibly redundant policy.

☐ Existing policy statements that would be superseded or deemed contrary to newly proposed policy are proposed for rescission.

☐ Information contained in the resolution has been checked for accuracy and, if applicable, includes appropriate reference citations to facilitate independent review.

☐ This item is an "information statement." An information statement may be submitted to bring an issue to the attention of the HOD. The item will be included as an informational item but will not go to a reference committee or be acted upon in any way by the House, unless extracted.

Notes:

* See Policy G-600.061, Guidelines for Drafting a Resolution or Report, for House policy on expectations for resolutions and their authors.

† AMA staff will develop fiscal notes for all resolutions. If a fiscal note is estimated to be over $5000, staff will notify sponsor of estimate. Sponsors of resolutions must declare any commercial or financial conflict of interest at the time the resolution is submitted.

1 New policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession. If adoption of the new policy could render obsolete or supersede one or more existing policies, those policies should be identified by number and recommended for rescission or revision.

2 This designation is intended for resolutions that call for specific amendments or modifications to existing policy. Please set out the pertinent text of the existing policy, citing the policy number and clearly identify the proposed modifications. If adoption of modified policy could render obsolete or supersede one or more existing policies, those policies should be identified by number and recommended for rescission.

3 Reaffirmation of existing policy should contain a clear restatement of the existing policy, citing the policy number.

4 This designation is for use if the intent of the resolution is to have the AMA take a specific action (conduct a study, lobby Congress, etc.) Directives to take action should include all elements required for establishing a new policy as well as a clear statement of existing policy, citing the policy number underlying the directive.

Send resolution to img@ama-assn.org

Policy Materials

Section resolutions

A. Resolution 206 – Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians
B. Resolution 307 – Implementation of Financial Education Curriculum for Students and Physicians in Training
C. Resolution 805 – Fair Medication Pricing for Patients in U.S.: Advocating for a Global Pricing Standard

House of Delegates reports/resolutions of interest

A. Resolution 304 – Issues with the Match, The National Residency Matching Program (NRMP)
B. Resolution 306 – Financial Burden of USMLE Step 2 CS on Medical Students
C. Resolution 802 – Ensuring Fair Pricing of Drugs Developed with the U.S. Government
D. Board of Trustees Report 1 – Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)
E. Board of Trustees Report 3 – Restriction on IMG Moonlighting
F. CME Report 1 – For-Profit Medical Schools or Colleges
G. CME Report 2 – Healthcare Finance in the Medical School Curriculum (Resolution 307, A-18)
H. CME Report 4 – Board Certification Changes Impact Access to Addiction Medicine Specialists
I. CME Report 5 – The Transition from Undergraduate Medical Education to Graduate Medical Education

J. CME Report 6 – Veterans Health Administration Funding of Graduate Medical Education
K. CMS Report 4 – Mechanism to Address High and Escalating Pharmaceutical Prices

House of Delegates grid

A. Annotated Reference Committee Grid

Policy making timeline

A-19 Summary of Actions

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-19)

Introduced by: International Medical Graduates Section
Minority Affairs Section

Subject: Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians

Referred to: Reference Committee B

Whereas, One in four of the practicing physician workforce in the United States of America are trained at an international medical school[1]; and

Whereas, 41% of the international medical graduates (IMG) serve in the primary care disciplines, as defined by the Association of American Medical Colleges (AAMC), including internal medicine, family medicine, pediatrics and geriatrics[2]; and

Whereas, An American Medical Association and American Osteopathic Association database study showed that the IMGs are more likely to serve in the rural persistent poverty areas in primary care, compared to their U.S, counterparts and DOs[3]; and

Whereas, By 2030, an estimated shortage of between 14,800 and 49,300 primary care physicians has been projected by a recent American Association of Medical Colleges report[4]; and

Whereas, The U.S. population aged over 65 is estimated to grow over 50% by 2030 and one third of the currently active physicians will be older than 65 in the next decade[4]; and

Whereas, If people in the underserved and rural areas and people without insurance would use healthcare the same way as the people with insurance and the people in the metropolitan areas; an additional 31,600 physicians were needed in 2016[4]; and

Whereas, Critical access hospitals in underserved areas continue to face a crisis due to uncompensated care and limited retention of physicians; and

Whereas, The residents of the rural and underserved areas tend to be older, more chronically ill, of a lower socioeconomic background and uninsured[5], resulting in significant disparities in rural and urban health care status and life expectancy[6]; and

Whereas, The overall number of U.S. medical graduates choosing careers as general internist has declined over many years and retention of general practice physicians remained a persistent challenge in improving health care access in these areas[7]; and

Whereas, A current Conrad 30 Reauthorization Bill (Senate Bill S948) has proposed a pathway for IMGs to serve in the federally designated health professional shortage area (HPSA) with a majority of Medicare/Medicaid and uninsured population for a longer duration, an increased number of IMGs to be available in each state to serve in these areas and have incentives to serve and settle in these areas; therefore be it

RESOLVED, That our American Medical Association support efforts to retain and incentivize international medical graduates serving in federally designated health professional shortage areas after the current allocated period. (Directive to Take Action).

Fiscal Note: Minimal - less than $1,000

Received: 10/01/19

1. About ECFMG: overview. Educational Commission for Foreign Medical Graduates website. http://www.ecfmg.org/about/index.html. Accessed February 8, 2015.
2. Center for Workforce Studies. *2013 State Physician Workforce Data Book.* Washington, DC: American Association of Medical Colleges; 2013. https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabook.pdf. Accessed August 14, 2019.
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RELEVANT AMA POLICY

US Physician Shortage H-200.954
Our AMA:
(1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
(2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
(3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
(4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
(5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
(6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health

centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians. Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.
4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.
5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.
6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.
7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.
8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.
9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.
10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.
11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these

efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.
12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.
13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).
14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.
15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.
16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these

and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
Citation: CME Rep. 04, I-18

Improving Rural Health H-465.994
1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Study efforts to optimize rural public health.

Citation: Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(I-19)

Introduced by: International Medical Graduates Section

Subject: Implementation of Financial Education Curriculum for Medical Students and Physicians in Training

Referred to: Reference Committee C

Whereas, Burnout is a crisis affecting the physician community in the United States. Burnout is reported to have a deleterious influence on more than half of the practicing physicians[1-7], up to 70% of medical students[8,9] and up to 75% of the physicians in training[5,10-15]; and

Whereas, The causes of burnout are multifactorial, but severity of burnout has been reported to increase with increase in financial debt[6,14,16-18]. Financial pressures had been found to increase resident burnout and negatively impact professionalism[19]. The residents with higher debt were found to have lower Quality of Life (QOL), lower satisfaction with work-life balance, higher emotional exhaustion and depersonalization[16]; and

Whereas, Medical students have high amounts of debt[14,20-24] contributed by a rapid increase both undergraduate[25] and medical education expenses[23,26]. African American medical students are reported to have more debt compared to others.[27] The high amount of student loan debt has a big impact on medical student's decision to choose a higher paying specialty[28-32]. This results in decreased interest in primary care specialties as the pay is low resulting in shortage of primary care providers[28-30,32]. There has been many proposals and initiatives to improve the crisis of medical school debt, but are not implemented widely[23,33]; and

Whereas, Debt grows significantly during the residency and fellowship period, up to 20 - 50% by the end of the training[14]. Once the residents graduate, the physicians will have to pay off the student loans which will take up 9-12% of their post-tax income[23], which will add a significant amount of financial stress on an early career physician; and

Whereas, Physicians are found to have poor financial literacy[14,34-40]. From a survey of orthopedic residents, it was reported that only 4% of the residents had a formal financial education, but 85% are interested in learning[41]; and

Whereas, There have been few attempts to improve the financial literacy by implementing a curriculum in personal finance during medical school and residency, but these opportunities are not widely available[14,34,36,41-48]; therefore be it

RESOLVED, That our American Medical Association work with relevant stakeholders to study the development of a curriculum during medical school and residency/fellowship training to educate them about the financial and business aspect of medicine. (Directive to Take Action)

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

Received: 10/01/19

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RELEVANT AMA POLICY

Cost and Financing of Medical Education and Availability of First-Year Residency Positions - H-305.988

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.
CME Rep. A, I-83 Reaffirmed: CLRPD Rep. 1, I-93Res. 313, I-95Reaffirmed by CME Rep. 13, A-97Modified: CME Rep. 7, A-05Modified: CME Rep. 13, A-06Appended: Res. 321, A-15Reaffirmed: CME Rep. 05, A-16Modified: CME Rep. 04, A-16

Principles of and Actions to Address Medical Education Costs and Student Debt- H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. 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).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel

individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.

14. Take an active advocacy role during reauthorization of the Higher Education Act and similar 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 federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. 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.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United

States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in 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; (i) 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.

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new polices and novel approaches to prevent debt from influencing specialty and subspecialty choice.

CME Report 05, I-18 Appended: Res. 953, I-18 Reaffirmation: A-19 Appended: Res. 316, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-19)

Introduced by: International Medical Graduates Section

Subject: Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard

Referred to: Reference Committee J

Whereas, Patients in the United States spend more on prescription medications than any other industrialized country according to the National Healthcare Expenditure, 333 billion dollars in 2017, up from 236 billion dollars in 2007; and

Whereas, Increases in prescription drug prices have resulted in many patients foregoing medication and putting lives at risk; while other countries such as Britain, the world's 20 top selling medications are three times cheaper than in the United States; and

Whereas, Data from a study of generic and brand name drug costs published in Health Affairs in January 2019 shows that generic drugs and brand name drugs increased in price from 9 to 21 percent per annum from 2005 through 2016; and

Whereas, Up to 85% of the raw ingredients used in the medications sold in the United States are produced outside of the country while our prices for pharmaceuticals per capita are the highest in the world; and

Whereas, Recent efforts to create an International Pricing Index to allow the Centers for Medicaid and Medicare to negotiate prices for medications in Part B, which leaves the majority of medications prescribed that are in Medicare Part D and from other sources unaffected; and

Whereas, New legislation efforts are focusing on the creation of an International Pricing Index that would identify only the 250 most costly medications each year and negotiate prices for only 25 of these medications per annum, would continue to leave the majority of medications unaffected; and

Whereas, The current legislative proposal would cap the price of medications at 120% of an International Pricing Index for only 25 medications each year, which may potentially still result in consumers experiencing an unfair burden of medication prices for the majority of medications; and

Whereas, The AMA is dedicated to promoting patient-centered quality healthcare that is accessible and affordable; it would be in the best interest for patient care and to minimize cost to better control medication prices; therefore be it

RESOLVED, That our American Medical Association advocate for legislation to create an International Pricing Index that would track global medication prices for all prescription medications and keep U.S. medication costs aligned with prices paid in other countries to help control costs and reduce unreasonable patient financial barriers to treatment (Directive to Take Action); and be it

RESOLVED, That our AMA advocate for legislation that would ensure that patients are charged fairly for prescription medications based on the International Pricing Index and that additional costs will not be arbitrarily assigned or passed onto patients. (Directive to Take Action)

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

Received: 10/01/19

References:
1) "Spending On Prescription Drugs In The US: Where Does All The Money Go?", Health Affairs Magazine; https://www.healthaffairs.org/do/10.1377/hblog20180726.670593/full/
2) "Retail prescription drug spending grew by $90 billion over four years," Modern Healthcare; https://www.modernhealthcare.com/technology/retail-prescription-drug-spending-grew-90-billion-over-four-years
3) "The Contribution Of New Product Entry Versus Existing Product Inflation In The Rising Costs Of Drugs,", Health Affairs; https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05147#EX1
4) "International Pricing Index: Outsourcing Negotiations Will Continue the US Drug Cost Crisis", Health Affairs Magazine: https://www.healthaffairs.org/do/10.1377/hblog20190307.887201/full/
5) "More Than 300 Groups Seek Halt to CMS Plans for Global Drug Pricing Index", American Journal of managed Care: https://www.ajmc.com/newsroom/more-than-300-groups-seek-halt-to-cms-plans-for-global-drug-pricing-index
6) "Why are Prescription Drug Prices Rising?" U.S. News & World Report, https://health.usnews.com/health-care/for-better/articles/2019-02-06/why-are-prescription-drug-prices-rising
7) "How the U.S. Pays 3 Times More for Drugs", Scientific American: https://www.scientificamerican.com/article/how-the-u-s-pays-3-times-more-for-drugs/

RELEVANT AMA POLICY

Price of Medicine H-110.991
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.
Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19

Cost of Prescription Drugs H-110.997
Our AMA:
(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.
Citation: BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Cost Sharing Arrangements for Prescription Drugs H-110.990
Our AMA:
1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition.
Citation: CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS Rep. 07, A-18

Drug Issues in Health System Reform H-100.964
The AMA: (1) consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.
(2) supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.
(3) reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.
(4) reaffirms AMA Policies H-120.974 and H-125.992, opposing the substitution of FDA B-rated generic drug products.
(5) supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.
(6) supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.
(7a) encourages physicians to counsel their patients about their prescription medicines and when appropriate, to supplement with written information; and supports the physician's role as the "learned intermediary" about prescription drugs.
(7b) encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.
(8) recognizes the role of the pharmacist in counseling patients about their medicines in order to reinforce the message of the prescribing physician and improve medication compliance.
(9) reaffirms AMA Policies H-115.995 and H-115.997, opposing FDA-mandated patient package inserts for all marketed prescription drugs.
(10) opposes payment of pharmacists by third party payers on a per prescription basis when the sole purpose is to convince the prescribing physician to switch to a less expensive "formulary" drug because economic incentives can interfere with pharmacist professional judgment.
(11) reaffirms AMA Policy H-120.991, supporting the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge, and to oppose legislation or regulation whose intent is to ban drug sampling.
(12) supports CEJA's opinion that physicians have an ethical obligation to report adverse drug or device events; supports the FDA's MedWatch voluntary adverse event reporting program; and supports FDA efforts to prevent public

disclosure of patient and reporter identities.
(13) opposes legislation that would mandate reporting of adverse drug and device events by physicians that would result in public disclosure of patient or reporter identities.
(14) reaffirms AMA Policy H-120.988, supporting physician prescribing of FDA-approved drugs for unlabeled indications when such use is based upon sound scientific evidence and sound medical opinion, and supporting third party payer reimbursement for drugs prescribed for medically accepted unlabeled uses.
(15) encourages the use of three compendia (AMA's DRUG EVALUATIONS; United States Pharmacopeial-Drug Information, Volume I; and American Hospital Formulary Service-Drug Information) and the peer-reviewed literature for determining the medical acceptability of unlabeled uses.
(16) reaffirms AMA Policy H-100.989, supporting the present classification of drugs as either prescription or over-the-counter items and opposing the establishment of a pharmacist-only third (transitional) class of drugs.
(17) reaffirms AMA Policy H-120.983, urging the pharmaceutical industry to provide the same economic opportunities to individual pharmacies as given to mail service pharmacies.
Citation: (BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11)

Controlling Cost of Medical Care H-155.966
The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, housestaff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general.
Citation: (Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12)

Patient and Public Education about Cost of Care H-155.980
The AMA, as a part of its program to strengthen the US health care system, supports intensifying its efforts to better understand patient concerns regarding fees and other costs of health care in all settings, including the cost of medication, and supports attempts to relieve these concerns.
Citation: (Res. 153, I-89; Sub. Res. 42, I-89; Reaffirmed in lieu of Res. 811, I-93; CMS Rep. 12, A-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 1, A-15)

Medicare Part B Competitive Acquisition Program (CAP) H-110.983
Our AMA will advocate that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:
(1) it must be genuinely voluntary and not penalize practices that choose not to participate;
(2) it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;
(3) it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate healthcare inflation rate;
(4) it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of CAP-acquired drugs at multiple office locations;
(5) it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
(6) it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
(7) it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
(8) it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.
Citation: Res. 216, I-18

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.

3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.
Citation: Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19

Maximum Allowable Cost of Prescription Medications H-155.962
Our AMA opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services.
Citation: CMS Rep. 2, A-07; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed: CMS Res. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmation: A-17

Managed Care Cost Containment Involving Prescription Drugs H-285.965
(1) Physicians who participate in managed care plans should maintain awareness of plan decisions about drug selection by staying informed about pharmacy and therapeutics (P&T) committee actions and by ongoing personal review of formulary composition. P&T committee members should include independent physician representatives. Mechanisms should be established for ongoing peer review of formulary policy. Physicians who perceive inappropriate influence on formulary development from pharmaceutical industry consolidation should notify the proper regulatory authorities.
(2) Physicians should be particularly vigilant to ensure that formulary decisions adequately reflect the needs of individual patients and that individual needs are not unfairly sacrificed by decisions based on the needs of the average patient. Physicians are ethically required to advocate for additions to the formulary when they think patients would benefit materially and for exceptions to the formulary on a case-by-case basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary exclusions should be established. Other cost-

containment mechanisms, including prescription caps and prior authorization, should not unduly burden physicians or patients in accessing optimal drug therapy.
(3) Limits should be placed on the extent to which managed care plans use incentives or pressures to lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness, not when they require withholding medically necessary care. Physicians must not be made to feel that they jeopardize their compensation or participation in a managed care plan if they prescribe drugs that are necessary for their patients but that may also be costly. There should be limits on the magnitude of financial incentives, incentives should be calculated according to the practices of a sizable group of physicians rather than on an individual basis, and incentives based on quality of care rather than cost of care should be used. Physician penalties for non-compliance with a managed care formulary in the form of deductions from withholds or direct charges are inappropriate and unduly coercive. Prescriptions should not be changed without physicians having a change to discuss the change with the patient.
(4) Managed care plans should develop and implement educational programs on cost-effective prescribing practices. Such initiatives are preferable to financial incentives or pressures by HMOs or hospitals, which can be ethically problematic.
(5) Patients must fully understand the methods used by their managed care plans to limit prescription drug costs. During enrollment, the plan must disclose the existence of formularies, the provisions for cases in which the physician prescribes a drug that is not included in the formulary and the incentives or other mechanisms used to encourage physicians to consider costs when prescribing drugs. In addition, plans should disclose any relationships with pharmaceutical benefit management companies or pharmaceutical companies that could influence the composition of the formulary. If physicians exhaust all avenues to secure a formulary exception for a significantly advantageous drug, they are still obligated to disclose the option of the more beneficial, more costly drug to the patient, so that the patient can decide whether to pay out-of-pocket.
(6) Research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare.
(7) Our AMA urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary.
(8) When pharmacists, insurance companies, or pharmaceutical benefit management companies communicate directly with physicians or patients regarding prescriptions, the reason for the intervention should be clearly identified as being either educational or economic in nature.
(9) Our AMA will develop model legislation which prohibits managed care entities, and other insurers, from retaliating against a physician by disciplining, or withholding otherwise allowable payment because they have prescribed drugs to patients which are not on the insurer's formulary, or have appealed a plan's denial of coverage for the prescribed drug.
(10) Our AMA urges health plans including managed care organizations to provide physicians and patients with their medication formularies through multiple media, including Internet posting.
(11) In the case where Internet posting of the formulary is not available and the formulary is changed, coverage should be maintained until a new formulary is distributed.
(12) For physicians who do not have electronic access, hard copies must be available.
Citation: CEJA Rep. 2, A-95; Res. 734, A-97; Appended by Res. 524 and Sub. Res.714, A-98; Reaffimed: Res. 511, A-99; Modified: Res. 501, Reaffirmed: Res. 123 and 524, A-00; Modified: Res. 509, I-00; Reaffirmed: CMS Rep. 6, A-03; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmation A-08; Reaffirmation A-10; Reaffirmed in lieu of Res. 822, I-11; Reaffirmation A-14; Reaffirmed: CMS Rep. 05, A-19

Low Cost Drugs to Poor Countries During Times of Pandemic Health Crises H-250.988
Our AMA: (1) encourages pharmaceutical companies to provide low cost medications to countries during times of pandemic health crises; and (2) shall work with the World Health Organization (WHO), UNAID, and similar organizations that provide comprehensive assistance, including health care, to poor countries in an effort to improve public health and national stability.
Citation: (Res. 402, A-02; Reaffirmed: CSAPH Rep. 1, A-12)

1.2.13 Medical Tourism
Medical tourists travel to address what they deem to be unmet personal medical needs, prompted by issues of cost, timely access to services, higher quality of care or perceived superior services, or to access services that are not available in their country of residence. In many instances, patients travel on their own initiative, with or without consulting their physician, and with or without utilizing the services of commercial medical tourism companies. The care medical tourists seek may be elective procedures, medically necessary standard care, or care that is unapproved or legally or ethically prohibited in their home system.
Many medical tourists receive excellent care, but issues of safety and quality can loom large. Substandard surgical care, poor infection control, inadequate screening of blood products, and falsified or outdated medications in lower income settings of care can pose greater risks than patients would face at home. Medical tourists also face heightened travel-related risks. Patients who develop complications may need extensive follow-up care when they return home. They may pose public health risks to their home communities as well.

Medical tourism can leave home country physicians in problematic positions: Faced with the reality that medical tourists often need follow-up when they return, even if only to monitor the course of an uneventful recovery; confronted with the fact that returning medical tourists often do not have records of the procedures they underwent and the medications they received, or contact information for the foreign health care professionals who provided services, asked to make right what went wrong when patients experience complications as a result of medical travel, often having not been informed about, let alone part of the patients decision to seek health care abroad. (IV, V, VI)
Physicians need to be aware of the implications of medical tourism for individual patients and the community. Collectively, through their specialty societies and other professional organizations, physicians should:
(a) Support collection of and access to outcomes data from medical tourists to enhance informed decision making.
(b) Advocate for education for health care professionals about medical tourism.
(c) Advocate for appropriate oversight of medical tourism and companies that facilitate it to protect patient safety and promote high quality care.
(d) Advocate against policies that would require patients to accept care abroad as a condition of access to needed services.
Individually, physicians should:
(e) Be alert to indications that a patient may be contemplating seeking care abroad and explore with the patient the individuals concerns and wishes about care.
(f) Seek to familiarize themselves with issues in medical tourism to enable them to support informed decision making when patients approach them about getting care abroad.
(g) Help patients understand the special nature of risk and limited likelihood of benefit when they desire an unapproved therapy. Physicians should help patients frame realistic goals for care and encourage a plan of care based on scientifically recognized interventions.
(h) Advise patients who inform them in advance of a decision to seek care abroad whether the physician is or is not willing to provide follow-up care for the procedure(s), and refer the patient to other options for care.
(i) Offer their best professional guidance about a patients decision to become a medical tourist, just as they would any other decision about care. This includes being candid when they deem a decision to obtain specific care abroad not to be in the patients best interests. Physicians should encourage patients who seek unapproved therapy to enroll in an appropriate clinical trial.
(j) Physicians should respond compassionately when a patient who has undergone treatment abroad without the physicians prior knowledge seeks nonemergent follow-up care. Those who are reluctant to provide such care should carefully consider:
(i) the nature and duration of the patient-physician relationship;
(ii) the likely impact on the individual patients well-being;
(iii) the burden declining to provide follow-up care may impose on fellow professionals;
(iv) the likely impact on the health and resources of the community.
Physicians who are unable or unwilling to provide care in these circumstances have a responsibility to refer the patient to appropriate services.

AMA Principles of Medical Ethics: IV, V, VI

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.

Issued: 2018

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-19)

Introduced by: Indiana

Subject: Issues with the Match, the National Residency Matching Program (NRMP)

Referred to: Reference Committee C

Whereas, A record number of physicians applied for residency programs through the National Residency Matching Program (NRMP) in 2019. The total was 44,603 with ultimately 2,718 withdrawing and 3,509 not fully completing the application process. Of the remainder who completed the Match program, only 79.6% of 38,376 matched, with 7,826 unmatched; and

Whereas, Applicants who do not match quickly the first time go through a secondary match called the SOAP (Supplemental Offer and Acceptance Program); and

Whereas, A growing discrepancy exists between the number of medical school graduates and available residency slots, causing the number of applicants who do not match each year to grow at a time when there is also a growing shortage of physicians, with a large number over age 60 who will be retiring within 10 years; and

Whereas, Medical school graduates typically incur a significant burden of academic loans through their years of education that is worsened by the fees charged to go through The Match process. (Costs ranging from $85 up to thousands of dollars.) The residency programs also pay the NRMP for their services, which range from $370 up to many thousands of dollars. Income generated by the match has become quite lucrative as the number of applicants grows from year to year. The Board of the NRMP has an obligation to be good stewards of these funds and to ensure that are spent wisely and frugally; and

Whereas, The SOAP gives applicants who fail to match in the first round an opportunity to find a position in a second-round matching process. This year, the SOAP website crashed on the first day it came online, preventing participants from entering their program of choice and the programs from seeing the list of those interested in positions. While the board extended the SOAP one additional day, this system failure undoubtedly affected the outcome of the secondary match for some individuals in both negative and positive ways. In other words, changing the procedure and process produced a different outcome than if the SOAP system had not failed; and

Whereas, Failure to match initially is an extremely stressful and difficult time, as applicants try to learn about residencies that have remaining slots. Applicants who do not match must scramble to sort out what they will do during the next year, when they typically apply again after discerning what contributed to their failure to match; and

Whereas, Failure to match for one year is serious, but the bigger tragedy is to have expended resources to become a physician and yet never match. This is also a waste of taxpayer dollars, since these individuals can never independently practice as physicians, and yet the state and nation have invested hundreds of thousands of dollars in their education; therefore be it

RESOLVED, That our American Medical Association redouble its efforts to promote an increase in residency program positions in the U.S. (Directive to Take Action); and be it further

RESOLVED, That our AMA assign an appropriate AMA committee or committees to:

- Study the issue of why residency positions have not kept pace with the changing physician supply and investigate what novel residency programs have been successful across the country in expanding positions both traditionally and nontraditionally.

- Seek to determine what causes a failure to match and better understand what strategies are most effective in increasing the chances of a successful match, especially after a prior failure. The committee(s) would rely upon the BNRMP (Board of the National Residency Matching Program) to provide some of this information through surveys, questionnaires and other means. Valid data would be valuable to medical students who seek to improve their chances of success in The Match.

- Report back to the AMA HOD with findings and recommendations (Directive to Take Action); and be it further

RESOLVED, Because SOAP (Supplemental Offer and Acceptance Program) failed to adequately serve some physicians seeking to match this year, that our AMA support the option to allow individuals participating in one future Match at no cost (Directive to Take Action); and be it further

RESOLVED, That in order to understand the cost of The Match and identify possible savings, our AMA encourage the Board of the National Residency Matching Program to:

1. Conduct an independent and fully transparent audit of SOAP (Supplemental Offer and Acceptance Program) to identify opportunities for savings, with the goal of lowering the financial burden on medical students and new physicians

2. Actively promote success for those participating in The Match by better explaining and identifying those issues that interfere with the successful match and to offer strategies to mitigate those issues. This information can be disseminated through the program website and through services such as its "Help" and "Q&A" links, and also through the AMA. (Directive to Take Action)

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

Received: 09/27/19

RELEVANT AMA POLICY

https://policysearch.ama-assn.org/policyfinder/search/Resident%20Match%20/relevant/1.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-19)

Introduced by: Indiana

Subject: Financial Burden of USMLE Step 2 CS on Medical Students

Referred to: Reference Committee C

Whereas, The cost of medical education and testing is rising, with no relief in sight for medical students; and

Whereas, The cost of USMLE Step 2 CS Exam will be $1,300 in 2020 and most medical students will have to travel and stay near one of the five national testing centers; and

Whereas, The USMLE Step 2 CS Exam costs approximately $27.5 million annually and nationally to medical students, not including travel expenses; and

Whereas, It should be noted that there is no good correlation between Board certification and physician competency; and

Whereas, There are no data to support a link between the USMLE Step 2 CS Exam and improved patient outcomes, and 95% of U.S. medical students pass on their first attempt; therefore be it

RESOLVED, That our American Medical Association work with the Federation of State Medical Boards/United States Medical Licensing Examination (USMLE) to reduce the cost of the USMLE Step 2 CS exam and allow medical students to take this exam locally to defray unnecessary expenses. (Directive to Take Action)

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

Received: 09/27/19

RELEVANT AMA POLICY

https://policysearch.ama-assn.org/policyfinder/detail/USMLE%20Step%202%20CS%20exam%20?uri=%2FAMADoc%2Fdirectives.xml-0-876.xml.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(I-19)

Introduced by: Medical Student Section

Subject: Ensuring Fair Pricing of Drugs Developed with the United States Government

Referred to: Reference Committee J

Whereas, The United States spends almost twice as much on healthcare as other comparable high income countries despite similar utilization rates, driven in part by higher spending on prescription drugs than other comparable nations[1,2,3,4,5,6,7]; and

Whereas, The United States spends between 30% and 190% more on pharmaceutical drugs per capita as compared to other comparable high income countries despite similar utilization rates[3,4,5,6]; and

Whereas, Many drugs cost significantly more in the United States than in other comparable industrialized countries, imposing an undue financial burden on American consumers of pharmaceutical compounds, particularly the uninsured, Medicare beneficiaries, and those whose insurance plans do not cover medicines they need[3,4,5,6,7,8]; and

Whereas, The United States government is the world's largest funder of the basic science research that supports the development of new pharmaceutical compounds[9,10,11]; and

Whereas, The United States government licenses drugs discovered in its laboratories to for-profit entities in order to facilitate commercialization[12,13,14]; and

Whereas, Numerous examples exist of drugs funded in whole or in part by the US government being sold in the United States for higher prices than in other comparable industrialized countries[3,15,16,17,18,19,20,21,22,23]; and

Whereas, Pharmaceutical companies and industry advocacy groups excuse high prices by explaining they are necessary for research and development of new drugs[25,26,27]; and

Whereas, A report by the US Government Accountability Office found that pharmaceutical sales increased by 45% globally over the period from 2006 to 2015 and two thirds of pharmaceutical companies saw their profit margins increase over that time period, while annual research and development investment in the United States increased by only 8% over the period from 2008 to 2014[28]; and

Whereas, Pharmaceutical companies have a higher average profit margin than all comparable industries, including software development which is often cited as a similar industry with high upfront R&D costs and low relative distribution costs[28,29]; and

Whereas, The United States pays an estimated 70% of all pharmaceutical profits obtained from OECD nations despite only accounting for 34% of the OECD's GDP[30]; and

Whereas, While the 1980 Bayh-Dole Act grants US government agencies the authority to unilaterally revoke licenses to companies or order that additional licenses be granted in order to ensure access (so-called "march in rights"), this extraordinary power has never been used to ensure fair pricing[31,32,33]; and

Whereas, The NIH has repeatedly decided that it does not have the statutory authority to use its march-in rights to force licensees to set fair prices for American consumers as this is under the purview of Congress[34,35,36]; and

Whereas, 29 European countries currently use a model called international reference pricing (IRP) to set drug prices whereby insurers and/or socialized healthcare programs agree to pay a maximum price for drugs set to an index of prices paid by comparable nations or use such an index as a benchmark for negotiations to set prices[37,38]; and

Whereas, Studies of the effectiveness of IRP have found that it lowers prices, increases utilization of drug classes to which the model is applied, and reduces expenditures with no negative effects on health outcomes[39,40,41,42,43]; and

Whereas, One of the most common concerns regarding IRP is that it may incentivize pharmaceutical companies to delay or eliminate product launches in countries with a lower willingness to pay[44,45,46,47]; and

Whereas, Analyses of IRP's effects on pharmaceutical product launch delay have found the effect is weak and is limited to countries with a lower willingness to pay[48,49,50]; and

Whereas, The United States is one of the nations with the highest willingness to pay in aggregate, implying IRP's tendency to delay pharmaceutical product launch in lower-income countries would likely not apply to the United States[8,9,47,48]; and

Whereas, The Institute for Medicare and Medicaid Innovation in the Department of Health and Human Services (HHS) has proposed a new model for Medicare Part B reimbursement for single-source pharmaceuticals and biologics to be phased into 50% of Medicare Part B plans between 2020 to 2025 that shifts the reimbursement structure to an IRP model, using 126% of the average price paid for a drug in 16 comparable OECD countries for which drug pricing information is widely and publicly available as a benchmark[2,49,50,51]; and

Whereas, Over the five years of its implementation, the proposed model is expected to save $17.2 billion overall including $3.4 billion in direct out-of-pocket savings without changing Medicare Part B's benefit structure[50,51]; and

Whereas, The AMA has expressed concern that the involuntary nature of the trial program may pose risks to patient access to necessary medications should third party vendors be unable to negotiate prices for drugs that fall at or under Medicare's target price for reimbursement[52]; and

Whereas, Existing AMA Policy (H-110.997, H-110.988, H-110.987, D-110.993, H-110.991, D-110.988, H-110.998, D-330.954) highlights the AMA's continuing commitment to lowering prescription drug costs, so long as physician freedom of choice is preserved and appropriate incentives for pharmaceutical research and development are maintained; therefore be it

RESOLVED, That our American Medical Association amend Policy H-110.987 by addition to read as follows:

Pharmaceutical Costs, H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
14. Our AMA will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as in individual solution or in conjunction with other approaches. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000

Received: 08/28/19

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RELEVANT AMA POLICY

Cost of Prescription Drugs H-110.997
Our AMA:(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; (2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in

making these choices; (3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products; (4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies; (5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies; (6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and (7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.
Citation: BOT Rep. O, A-90 Sub. Res. 126 and Sub. Res. 503, A-95 Reaffirmed: Res. 502, A-98 Reaffirmed: Res. 520, A-99 Reaffirmed: CMS Rep. 9, I-99 Reaffirmed: CMS Rep.3, I-00 Reaffirmed: Res. 707, I-02 Reaffirmation A-04 Reaffirmed: CMS Rep. 3, I-04 Reaffirmation A-06 Reaffirmed in lieu of Res. 814, I-09 Reaffirmed in lieu of Res. 201, I-11 Reaffirmed in lieu of: Res. 207, A-17 Reaffirmed: BOT Rep. 14, A-18

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.
Citation: Sub. Res. 106, A-15 Reaffirmed: CMS 2, I-15 Reaffirmed in lieu of: Res. 817, I-16 Reaffirmed in lieu of: Res. 207, A-17 Reaffirmed: BOT Rep. 14, A-18

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
Citation: CMS Rep. 2, I-15 Reaffirmed in lieu of: Res. 817, I-16 Appended: Res. 201, A-17 Reaffirmed in lieu of: Res. 207, A-17 Modified: Speakers Rep. 01, A-17 Appended: Alt. Res. 806, I-17 Reaffirmed: BOT Rep. 14, A-18 Appended: CMS Rep. 07, A-18 Appended: BOT Rep. 14, A-19 Reaffirmed: Res. 105, A-19

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

Price of Medicine H-110.991
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.
Citation: CMS Rep. 6, A-03 Appended: Res. 107, A-07 Reaffirmed in lieu of: Res. 207, A-17 Appended: Alt. Res. 806, I-17 Reaffirmed: BOT Rep. 14, A-18 Appended: CMS Rep. 07, A-18 Reaffirmation: A-19 Appended: Res. 126, A-19

Prescription Drug Price and Cost Transparency D-110.988
1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.
2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign.
Citation: Alt. Res. 806, I-17

Cost of New Prescription Drugs H-110.998
Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.
Citation: Res. 112, I-89 Reaffirmed: Res. 520, A-99 Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmed in lieu of Res. 229, I-14

Prescription Drug Prices and Medicare D-330.954
1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.
Citation: Res. 211, A-04 Reaffirmation I-04 Reaffirmed in lieu of Res. 201, I-11 Appended: Res. 206, I-14 Reaffirmed: CMS Rep. 2, I-15 Appended: Res. 203, A-17

REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-I-19

Subject: Legalization of the Deferred Action for Legal Childhood Arrival (DALCA) (Resolution 205-I-18)

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 205-I-18, "Legalization of the Deferred Action for Legal Childhood Arrival (DALCA)" for study. Resolution 205-I-18 was introduced by the International Medical Graduates (IMG) Section. Resolution 205 asked that our AMA support legalization of DALCA; and that our AMA work with the appropriate agencies to allow DALCA children to start and finish medical school and/or residency training until these DALCA children have officially become legal.

BACKGROUND

DALCA is a new policy term not widely used by immigration attorneys or Members of Congress, and it is not a legally recognized term. The term was created to distinguish children of H-1B visa holders who legally entered the U.S. from Deferred Action for Childhood Arrivals (DACA) recipients. The term DACA applies only to children who were brought to the United States illegally and thus does not apply to children of H-1B visa holders, including International Medical Graduates (IMGs).

Under current U.S. immigration law, the spouse and children of a H-1B visa holder can accompany the worker to the U.S. by obtaining an H-4 visa. Each family member must obtain his or her own H-4 visa. There are a number of extensions for H-1B holders once an I-140 application (i.e., petition for green card) is approved. For those on H-4 spousal visas, there are no limitations as long as the related H-1B visa is valid. Additionally, in 2015 the Obama Administration issued a final rule allowing those on H-4 spousal visas to work if their H-1B visa spouse is applying to become a lawful permanent resident (i.e., green card holder). According to the U.S. Citizenship and Immigration Services (USCIS), there have been close to 91,000 initially approved employment authorization applications for H-4 spousal visas. However, children lose their H-4 visa status once they turn 21. These children have only two choices: they can have their H-4 visa changed to an international student visa, also called the student F-1 visa, so they can attend college/university in the U.S., or they can return to their home country and then return to the U.S. after their H-1B visa physician parent obtains permanent residency. Once these children finish their education while on the F-1 visa, they would need to seek H-1B employment sponsors of their own so they can work in the U.S. and eventually obtain their own green cards.

DISCUSSION

The sponsors of Resolution 205 assert that many DALCA children are in medical school or have already graduated from U.S. medical schools, but are subject to deportation because they are considered illegal once they are over age 21. Many of the DALCA children have matched in residency programs but are unable to attend due to their lack of proper legal status.

It is well known that there is expected to be a physician shortage in the U.S. The projected shortage of between 46,900 and 121,900 physicians by 2032 includes both primary care (between 21,100 and 55,200) and specialty care (between 24,800 and 65,800). Among specialists, the data project a shortage of between 1,900 and 12,100 medical specialists, 14,300 and 23,400 surgical specialists, and 20,600 and 39,100 other specialists, such as pathologists, neurologists, radiologists, and psychiatrists, by 2032. Supporting permanent legal status for DALCA children could help in reducing the impact of the expected physician shortage and support the families of H-1B visa physicians.

The AMA has extensive policy supporting DACA students as well as permanent residence status for physicians; however, there is no policy directly supporting children on H-4 visas that have aged out waiting for their physician-parent to receive their green card. The Board concludes that Resolution 205 is consistent with existing AMA policy and should be adopted by appropriately amending existing policy to incorporate the intent of the resolution.

RECCOMENDATION

The Board recommends that our AMA amend Policy D-255.979, "Permanent Residence Status for Physicians on H1-B Visas," by addition to read as follows, in lieu of Resolution 205-I-18 and that the remainder of the report be filed:

> Our AMA will work with all relevant stakeholders to: 1) clear the backlog for conversion from H1-B visas for physicians to permanent resident status, and 2) allow the children of H-1B visa holders, who have aged out of the H-4 non-immigrant classification, to remain in the U.S. legally while their parents' green card applications are pending. (Modify Current HOD Policy)

Fiscal Note: Less than $500

RELEVANT AMA POLICIES

Policy D-255.979, "Permanent Residence Status for Physicians on H1-B Visas"
Our AMA will work with all relevant stakeholders to clear the backlog for conversion from H1-B visas for physicians to permanent resident status.
Res. 229, A-18

Policy 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

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

Policy D-255.99, "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

Policy 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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-I-19

Subject: Restriction on IMG Moonlighting (Resolution 204-I-18)

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

Referred to: Reference Committee B

INTRODUCTION

At the 2018 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) referred Resolution 204-I-18, "Restriction on IMG Moonlighting." Resolution 204 was introduced by the Resident and Fellow Section.

> Resolution 204 asks that our AMA advocate for changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight.

This report provides a brief background on the J-1 visa program and discusses the issues that are raised when considering changes to federal legislation that would allow physicians with a J-1 visa in fellowship training programs the ability to moonlight.

BACKGROUND

The U.S. generally requires citizens of foreign countries to obtain a U.S. visa prior to entry. Based on the purpose of travel, an individual may receive one of two types of visas: immigrant and non-immigrant. Immigrant visas are issued to individuals who wish to live in the U.S. permanently, while non-immigrant visas are issued to individuals with permanent residence outside the U.S. who wish to be in the U.S. temporarily for tourism, business, temporary work, or other specified purposes.

The Exchange Visitor (J) non-immigrant visa category is for individuals approved to participate in work- and study-based exchange visitor programs. The first step in pursuing an exchange visitor visa is to apply through a designated sponsoring organization in the U.S. Physicians may be sponsored for J-1 status by the Educational Commission for Foreign Medical Graduates (ECFMG) for participation in accredited clinical programs or directly associated fellowship programs. These sponsored physicians have J-1 "alien physician" status and pursue graduate medical education or training at a U.S. accredited school of medicine or scientific institution, or pursue programs involving observation, consultation, teaching, or research. The J-1 classification is explicitly reserved for educational and cultural exchange.

J-1 status physicians are participants in the U.S. Department of State (DoS) Exchange Visitor Program. The primary goals of the Exchange Visitor Program are to allow participants the opportunity to engage broadly with Americans, share their culture, strengthen their English language abilities, and learn new skills or build skills that will help them in future careers.

According to the DoS, for Calendar Year 2018, there were 2,738 new J-1 physicians participating in the exchange program. For CY 2018 the top three "sending countries" for J-1 physicians were: Canada 689; India 489; and Pakistan 248. The top three "receiving U.S. states" for J-1 physicians were: New York 556; Michigan 182; and Texas 163.[1]

DISCUSSION

A J-1 visa holder may only perform the curricular activity listed on his/her Form DS-2019, or as provided for in the regulations for the specific category for which entry was obtained and with the approval of the Sponsor's Responsible or Alternate Responsible Officer. As a result, J-1 physician participants are not currently permitted to engage in any work outside of their approved program of graduate medical education. If the proposed activity by the J-1 physician falls outside of the normal scope and/or is not a required component of the training program, then it is deemed to be "work outside of the approved training program" and not permitted for J-1 physicians.

In June 1999, the U.S. Information Agency issued a statement of policy on the Exchange Visitor Program. In the statement of policy, the agency specifically comments on the ability of J-1 physicians to moonlight, stating that, "…a foreign medical graduate is not authorized to 'moonlight' and is without work authorization to do so. A foreign medical graduate may receive compensation from the medical training facility for work activities that are an integral part of his or her residency program. The foreign medical graduate is not authorized to work at other medical facilities or emergency rooms at night or on weekends. Such outside employment is a violation of the foreign medical graduate's program status and would subject the foreign medical graduate to termination of his or her program."[2]

The Administration has further outlined its rationale on this issue in a formal Notice of Proposed Rulemaking (NPRM) and later a final rule which strengthens the program's oversight by requiring management reviews for Private Sector Program sponsors of, for instance, alien physicians. The final rule confirmed the policy prohibiting moonlighting as outlined in 22 U.S. Code of Federal Regulations (CFR) §62.16:

> 22 CFR (§62.16) – Employment
> (a) An exchange visitor may receive compensation from the sponsor or the sponsor's appropriate designee, such as the host organization, when employment activities are part of the exchange visitor's program.
> (b) An exchange visitor who engages in unauthorized employment shall be deemed to be in violation of his or her program status and is subject to termination as a participant in an exchange visitor program.
> (c) The acceptance of employment by the accompanying spouse and dependents of an exchange visitor is governed by Department of Homeland Security regulations.

Currently, 42 CFR §415.208 provides substantial regulations for the services of moonlighting residents who are not foreign nationals. Again, the particular purpose of the J-1 program is to increase mutual understanding between the people of the U.S. and the people of other countries by means of educational and cultural exchanges. Thus, because J-1 physicians are foreign nationals participating in an educational/cultural exchange program offered by the DoS, they are not permitted to moonlight or receive additional compensation outside of the J-1 visa program.

DoS' final rule states that strict oversight of the exchange program is critical as an affirmative step "to protect the health, safety and welfare of foreign nationals." When problems occur, "the U.S. Government is often held accountable by foreign governments for the treatment of their nationals,

regardless of who is responsible." Any changes to program policy that may weaken protections could have "direct and substantial adverse effects on the foreign affairs of the U.S.."[3]

In accordance with the DoS policy, the AMA also has strong and lengthy policy outlining the rights of residents/fellows and limiting duty hours to ensure patient safety and an optimal learning environment for these physicians.

Those in support of Resolution 204 argue that moonlighting will improve access to care for underserved populations in certain areas around the U.S. facing a physician shortage. Allowing J-1 physicians to moonlight would provide these physicians with an increased opportunity to provide care to underserved populations while at the same time garner increased training and education during their time in the U.S. However, under the current program's purpose and restrictions, as set out by the Administration, this activity is not possible without significant changes to the J-1 program.[4]

Both the DoS and ECFMG ultimately desire that the J-1 visa program remain as a training/education program for which participants are paid. According to the DoS and ECFMG, if the alien physician program shifts to something other than a training/education program, then it will receive increased scrutiny (as is the case regarding the au pair and summer work travel programs) and could potentially be absorbed into the current immigration discussions between the U.S. Congress and the Administration. While the Board understands and appreciates the intent of the sponsors of Resolution 204, we conclude that the focus of the J-1 program should remain on the training and education of the physicians in the program and that our AMA should not pursue changes that could create a risk to those physicians and potentially the entire program.

RECOMMENDATION

The Board recommends that our American Medical Association not adopt Resolution 204-I-18, "Restriction on IMG Moonlighting," and that the remainder of the report be filed.

Fiscal Note: Less than $500

[1] https://j1visa.state.gov/wp-content/uploads/2019/03/Alien-Physician-Flyer-2018-web.pdf
[2] https://www.govinfo.gov/content/pkg/FR-1999-06-30/pdf/99-16757.pdf, 64 Federal Register 34983
[3] https://www.govinfo.gov/content/pkg/FR-2014-10-06/pdf/2014-23510.pdf, 79 Federal Register 60305
[4] Id.

RELEVANT AMA POLICY

CME Report on Duty Hours, CME Report 5, A-14

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. Citation: (Res. 309, A-03; Reaffirmed: CME Rep. 2, A-13)

Policy 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

Policy H-310.912, "Residents and Fellows' Bill of Rights"
1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines. 2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills. 3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders through various publication methods (e.g., the AMA GME e-letter) this Residents and Fellows' Bill of Rights. 4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of $200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended. 5. Our AMA encourages teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation. 6. Our AMA adopts the following 'Residents and Fellows' Bill of Rights' as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENTS AND FELLOWS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice. With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings. B. Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. C. Regular and timely feedback and evaluation based on valid assessments of resident performance. With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request. D. A safe and supportive workplace with appropriate facilities. With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract. E. Adequate compensation and benefits that provide for resident well-being and health. (1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal. (2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences. (3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act. F. Duty hours that protect patient safety and facilitate resident well-being and education. With regard to duty hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with duty-hour requirements set forth by the ACGME or other relevant accrediting body; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that duty-hour requirements are effectively circumvented. G. Due process in cases of allegations of misconduct or poor performance. With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA. H. Access to and protection by institutional and accreditation authorities when reporting violations. With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program

for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.
CME Rep. 8, A-11 Appended: Res. 303, A-14 Reaffirmed: Res. 915, I-15 Appended: CME Rep. 04, A-16

Policy H-310.979, "Resident Physician Working Hours and Supervision"
(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (a) Exemplary patient care is a vital component for any program of graduate medical education. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited residency program. Graduate medical education must never compromise the quality of patient care. (b) Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents. (c) Institutional commitment to graduate medical education must be evidenced by compliance with Section III.B.4 of the ACGME Institutional Requirements, effective July 1, 2007: The sponsoring institution's GME Committee must [m]onitor programs' supervision of residents and ensure that supervision is consistent with: (i) Provision of safe and effective patient care; (ii) Educational needs of residents; (iii) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (iv) Other applicable Common and specialty/subspecialty specific Program Requirements. (d) The program director must be responsible for the evaluation of the progress of each resident and for the level of responsibility for the care of patients that may be safely delegated to the resident. (e) Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times. (f) The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with Residency Review Committee (RRC) recommendations, and in compliance with the ACGME duty hour standards. (g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services." (h) As stated in the ACGME Institutional Requirements (II.F.2.a-c), "The Sponsoring Institution must provide services and develop health care delivery systems to minimize residents' work that is extraneous to their GME programs' educational goals and objectives." These include patient support services, laboratory/pathology/radiology services, and medical records. (i) Is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. As stated in the ACGME Common Program Requirements (VI.B) "the program must ensure that qualified faculty provide appropriate supervision of residents in patient care activities." (j) Individual resident compensation and benefits must not be compromised or decreased as a result of these recommended changes in the graduate medical education system. (2) These problems should be addressed within the present system of graduate medical education, without regulation by agencies of government.
CME Rep. C, I-87 Modified: Sunset Report, I-97 Modified and Reaffirmed: CME Rep. 2, A-08

Policy D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety"
Our American Medical Association will actively participate in ongoing efforts to monitor the impact of resident duty hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians.
Res. 314, A-03 Reaffirmation A-12

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-19

Subject: For-Profit Medical Schools or Colleges

Presented by: Jacqueline A. Bello, MD, Chair

American Medical Association (AMA) Policy D-305.954, "For-Profit Medical Schools or Colleges," states:

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

The Council on Medical Education recognized the importance and timeliness of this topic and agreed that appropriate resources and data collection were needed to study this issue and prepare the report. However, meaningful and constructive review of this issue and the data collection required additional time. The Council therefore is presenting this report at the 2019 Interim Meeting.

For-profit medical schools are a rare phenomenon within the United States, and the numbers of these schools have not increased substantially, with only six for-profit U.S. medical schools. That said, there are a large and growing number of for-profit medical schools located in the Caribbean that are attended by U.S. citizens. This report focuses on for-profit medical schools located in the United States, and provides available attrition rates, general financial information associated with students who attend for-profit vs. not-for-profit medical schools, and data on student transition into residency programs. Very limited data are also included on for-profit medical schools located in the Caribbean, as such data are not publicly available.

BACKGROUND

In the 19th century, the majority of medical schools were the property of the faculty and, therefore, could be considered "for-profit." In 1906, early accreditation standards from the Council on Medical Education required that schools not be conducted for the financial benefit of the faculty. A 1996 ruling against the American Bar Association, related to restraint of trade, opened up the possibility of accreditation of for-profit law schools and set a legal precedent for the establishment of for-profit medical schools.[1-3] Currently, medical school accreditation bodies, including the Liaison Committee on Medical Education (LCME) and American Osteopathic Association Commission on Osteopathic College Accreditation (COCA), are responsible for reviewing the financial status of U.S. medical schools and monitoring graduation rates and student debt.

Four for-profit osteopathic medical schools are in various stages of becoming accredited by COCA. In 2007, provisional accreditation was granted to investor-owned Rocky Vista University College of Osteopathic Medicine in Colorado.[1] The College was founded to address the need for community-based primary care physicians in the Mountain West region. The Burrell College of

Osteopathic Medicine at New Mexico State University, a privately funded osteopathic medical school founded in 2013, holds pre-accreditation status from COCA, and is expected to be fully accredited when its first class graduates in 2020.[4] In 2016, the Idaho College of Osteopathic Medicine and the California Health Sciences University College of Osteopathic Medicine were founded to help address regional physician shortages in underserved areas.[5] Both schools have initiated the accreditation process with COCA.

The LCME, by comparison, has granted accreditation to two for-profit allopathic medical schools. In 2013, the LCME modified its standards to remove mention of "for-profit" in the accreditation of allopathic medical schools.[1] One year later, Ponce Health Sciences University School of Medicine (a 35-year-old not-for profit institution in Puerto Rico reported to be in financial distress) was acquired by Arist Medical Sciences University, a for-profit public benefit corporation, making it the first for-profit allopathic medical school accredited by the LCME.[1] In 2015, California Northstate University College of Medicine, a private, for-profit medical school focused on educating, developing, and training physicians to address the primary care physician shortage in northern California, gained preliminary accreditation from the LCME and enrolled its first class of students.[6]

FOR-PROFIT MEDICAL SCHOOLS IN THE CARIBBEAN

There is a growing number of for-profit medical schools located in the Caribbean, often referred to as "offshore medical schools."[7] Accreditation/approval of these schools is the purview of a variety of bodies, each with varying standards and requirements for quality and duration of education. Currently,75 offshore medical schools are acceptable to the Educational Commission for Foreign Medical Graduates (ECFMG) for graduates to obtain ECFMG certification.[8] Offshore schools typically engage in minimal clinical or scientific research. As a result, offshore proprietary schools have a profitable business model in that their costs are mainly related to the educational program. These schools use their tuition revenue to pay faculty to teach in the basic sciences at U.S. hospitals, and as part of their tuition third- and fourth-year medical students pay to take clinical rotations in the United States.

There are no summary data available on the enrollment of U.S. citizens in offshore medical schools. However, an estimate can be made based on the number of U.S. citizens pursuing certification by the ECFMG. Of the 9,430 ECFMG certificates issued in 2018, 2,398 (25.4 percent) were issued to U.S. citizen graduates of offshore medical schools.[9] The students/graduates registering for certification were from medical schools located in countries in the Caribbean.

ATTRITION RATES

Not-for-profit U.S. Medical Schools

The Association of America Medical Colleges (AAMC) reports that from 1993-1994 through 2012-2013, the total national attrition rate for not-for-profit medical schools remained relatively stable at an average of 3.3 percent (Appendix A, Table 1).[10] The AAMC notes that more medical students left medical school for nonacademic than for academic reasons, and that attrition rates appeared to vary by type of degree program—that is, the attrition rates of students in combined degree programs, such as MD-MPH programs, differ from those for students in MD programs.

The American Association of Colleges of Osteopathic Medicine (AACOM) calculates attrition rate by dividing the sum of students who withdrew or took a leave of absence by total enrollment. Withdrawals and dismissals are types of permanent attrition from the colleges of osteopathic

medicine (COM), while leaves of absence are types of temporary attrition that may become a withdrawal or dismissal after a period of time.[11] Reasons for students' withdrawals/dismissals include academic failure or school policy violation; poor academic standing; transferring to another medical school; medical or personal reasons; changes in career plans; and failure to take or pass COMLEX (per COM policy). Reasons for leaves of absence include poor academic performance/remediation; academic enrichment/research/study for another degree; medical or personal reasons; and failure to take or pass COMLEX (per COM policy). AACOM only reports on those schools with a full four-year enrollment.

Attrition rates for all COMs ranged from a low of 2.63 percent (2009-2010) to a high of 3.59 percent (2012-2013), with an average 3.03 percent attrition rate from 2009-2010 through 2018-2019 (Table 1).[11] AACOM reports that first-and third-year students had a higher rate of attrition than their second- and fourth-year counterparts, due largely to the struggles first-year students experience when adjusting to the rigors of medical school and to COMLEX being administered to third-year students.

For-profit Medical Schools

Ponce Health Sciences University School of Medicine reports on its website that its average attrition rate for 2016-2017 was 2.3 percent (Table 1).[12] Although actual attrition rates are not available for California Northstate University College of Medicine, the school's website notes that a total of 60 new students enrolled in fall 2015, one student left the program, and three students fell back a year, with a total attrition of one student (1.7 percent).[13] Rocky Vista University College of Osteopathic Medicine, the only COM that has a full class (four years of students enrolled), reports on its website that 91 percent of Title IV students complete the program within four years.[14] Data on attrition rates for newer U.S. medical and osteopathic schools as well as offshore medical schools are not available.

FINANCIAL BURDEN

Not-for-profit U.S. Medical Schools

In 2018-2019, the median annual tuition and fees at state medical schools were $38,202; at private medical schools the median cost was $61,533 (Appendix B, Table 2).[15] In 2019, for students who attended state medical schools, the median debt was $190,000; for students who attended private medical schools, the median debt was $210,000.[15] The overall mean osteopathic medical education debt reported by academic year 2017-2018 graduates is $254,953 ($222,972 for public schools and $261,133 for private schools).[16]

For-profit Medical Schools

The four-year estimated tuition, fees, and cost of attending a for-profit U.S. medical school can range from $209,000 to $342,000 (Table 2). Rocky Vista University College of Osteopathic Medicine reports that four-year estimated tuition, fees, and costs is $215,748, and its typical graduate leaves with $294,018 debt.[17] Median student loan debt accrued for attending an offshore medical school ranges from $191,500 (Ross University School of Medicine) to $253,072 (American University of the Caribbean School of Medicine).[7]

SUCCESS OF U.S. GRADUATES IN OBTAINING A RESIDENCY POSITION

Not-for-profit U.S. Medical Schools

The National Resident Matching Program (NRMP) defines a successful match into a residency program as "one that is measured not just by volume, but also by how well it matches the preferences of applicants and program directors."[18] In 2019, U.S. allopathic medical school senior students comprised 18,925 of the active applicants, and the first-year post-graduate (PGY-1) Match rate for U.S. seniors was 93.9 percent.[18]

In 2019, the transition to a single accreditation system resulted in higher participation among students and graduates of U.S. osteopathic medical schools. An all-time high of 6,001 DO candidates submitted NRMP rank and order lists of programs, and the 84.6 percent PGY-1 match rate was the highest in history.[18]

Earlier Match data reflected NRMP and AOA National Matching Service (NMS) systems. Data reported by the COMs show that 98.7 percent of spring 2018 graduates seeking GME successfully placed into GME as of April 12, 2018.[19] This represents 6,224 new physicians beginning their graduate medical education in July 2018.[19] This compares to the 2017 match/placement process, when 5,898 new physicians entered GME (99.3 percent of graduates seeking GME) and 2016, when 5,356 graduates were successfully matched/placed—99.6 percent of graduates seeking to enter GME.[19]

The 2020 Match will be the first single match system administered by the NRMP, to include both allopathic and osteopathic residency programs. This single system will simplify the matching process for osteopathic medical school students. A result of the new process will be a shift in the way the Match rate percentage is reported.

For-profit Medical Schools

The California Northstate University College of Medicine class of 2019 had a 96.3 percent overall Match rate.[20] Rocky Vista University College of Osteopathic Medicine reported that the majority of students (79 percent) found a residency placement through the 2019 NRMP match, while other students matched into their top choices through the AOA Intern/Resident Registration Program (12 percent) or into military-specific residency programs (nine percent).[21]

However, fewer students matched into U.S. residency programs at some of the other for-profit schools. For example, Ponce Health Sciences University School of Medicine reported that its 2016-2017 initial residency Match rate (aside from the Supplemental Offer and Acceptance Program, or SOAP) was 89.4 percent, vs. 84.4 percent in 2017-2018.[12] In 2019, 5,080 U.S. IMGs (primarily graduates of offshore medical schools) participated in the NRMP, and 59 percent (n=2,997) successfully matched.[18]

LEVEL OF SUPPORT FOR GRADUATE MEDICAL EDUCATION

All U.S. allopathic and osteopathic medical schools are required to prepare their students to successfully transition into Accreditation Council for Graduate Medical Education (ACGME)-accredited GME programs. Two new for-profit osteopathic medical schools are in the process of developing their GME programs. Burrell College of Osteopathic Medicine at New Mexico State University has facilitated the ongoing development of new residency programs in family medicine, internal medicine, orthopaedic surgery, and osteopathic neuromusculoskeletal medicine, and

additional new GME programs are under development.[22] The leadership at the Idaho College of Osteopathic Medicine body is also focused on being able to provide its students with a high-quality academic and clinical clerkship experience and facilitating their placement into ACGME-accredited residency programs.[23]

Concern has been raised about the paucity of academic teaching hospitals associated with some for-profit medical schools. For example, students who attend Rocky Vista University College of Osteopathic Medicine complete clinical rotations at various hospitals throughout the state of Colorado and the mountain west region.[24] Third- and fourth-year medical students in their clerkships could be sent for rotations to nonacademic community hospitals without a strong background in education and research.[24] Although the college was established on the premise that physicians practice in locations close to their residency or fellowship programs, many of the graduates have had to leave the state to complete residency training requirements.[24]

Offshore for-profit medical schools, including those in the Caribbean, continue to provide a large number of medical school graduates who return to the United States for GME.[24] However, the accreditation standards these schools are held to, if any, vary widely and may not require that the schools provide career counseling or support for the transition of their students into ACGME-accredited programs.[25]

RELEVANT AMA POLICY

The AMA has extensive policy related to the cost and financing of medical education.

Policy H-305.925 (20f), "Principles of and Actions to Address Medical Education Costs and Student Debt," states that the costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue related to the Public Service Loan Forgiveness (PSLF) Program, the AMA will advocate that the profit status of a trainee's institution not be a factor for PSLF eligibility.

Policy H-200.949 (3), "Principles of and Actions to Address Primary Care Workforce," directs the AMA, through its work with stakeholders, to encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

Policy D-295.309, "Promoting and Reaffirming Domestic Medical School Clerkship Education," directs the AMA to support agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas.

Additional related policies are provided in Appendix C.

SUMMARY

Stigma and reputational challenges associated with for-profit medical schools can be traced back to the 1910 Flexner Report on Medical Education in the United States and Canada, which called for quality education that linked medical schools with universities and teaching hospitals.[3] The report criticized for-profit schools, and the subsequent linkage between accreditation and licensure requirements led to the collapse of many proprietary medical schools. However, for-profit medical education has reemerged in the United States and has expanded in the Caribbean and elsewhere around the world.[7, 24] The Ponce Health Sciences University School of Medicine was recently incorporated to facilitate the retention of public benefit.[1]

For-profit schools are based on a tuition-dependent business model. For example, at Rocky Vista University College of Medicine approximately 80 percent of revenue, as with the other private osteopathic medical schools, comes from tuition and fees. In contrast, tuition and fees constitute only 14 percent of public osteopathic medical schools' revenues.[24]

As with any medical school, for-profit medical schools may have a positive impact on the physician workforce. For example, the mission of California Northstate University College of Medicine is to train primary care physicians to serve the needs in underserved areas in northern California. As with other medical schools, however, the graduates of U.S. for-profit medical schools are subject to competition for residency placements. Graduates from for-profit medical schools in the Caribbean need to complete the requirements for ECFMG certification before they can apply for residency training in the United States.

Through its Council on Medical Education, the AMA will continue to monitor the development of for-profit medical schools, both allopathic and osteopathic, and report back to the House of Delegates as needed.

APPENDIX A
TABLE 1. ATTRITION RATE OF STUDENTS ATTENDING U.S. MEDICAL SCHOOLS

Not-for-profit	***Attrition Rate:***
U.S. allopathic medical schools	From 1993-1994 through 2012-2013, the total national attrition rate remained relatively stable at an average of 3.3%[1]
U.S. osteopathic medical schools	From a low of 2.63% (2009-10) to a high of 3.59% (2012-13), with an average of 3.03% attrition rate from 2009-10 through 2018-19.[2]
For-profit*	***Attrition Rate:***
Ponce Health Sciences University School of Medicine	Average attrition rate is 2.3%; retention rate is 97.7% (2016-2017)[3]
California Northstate University College of Medicine**	Total of 60 new students enrolled in the Fall of 2015; one student left the program and three students fell back a year; the total attrition of 1 student (1.7%).[4]
Rocky Vista University College of Osteopathic Medicine**	91% of Title IV students complete the program within 4 years with an attrition rate of 9%.[5]
Burrell College of Osteopathic Medicine at New Mexico State University**	Matriculated 162 students in 2018; retained 154 (95.06%) with an attrition rate of 4.94%.[6]
Idaho College of Osteopathic Medicine***	Matriculated its inaugural class in August 2018. This class of 2022 is composed of graduates from 97 U.S. colleges and universities, with above average composite medical board (MCAT) scores and highly competitive undergraduate grade point averages.[7]
California Health Sciences University College of Osteopathic Medicine***	Campus construction underway with targeted completion date of Spring 2020.

* *Similar quality data are not available from offshore medical schools*
** *Attrition rate is extrapolated from the retention rate posted on the medical school's website.*
*** *Data on attrition rates for newer U.S. medical schools are not yet available.*

1. AAMC Data Snapshot. Association of American Medical Colleges. Available at: https://www.aamc.org/download/492842/data/graduationratesandattritionratesofu.s.medicalstudents.pdf (Accessed April 9, 2019).
2. 2019-2020 Student Guide to Osteopathic Medical Colleges. American Association of Colleges of Osteopathic Medicine. 2019. Available at: https://www.aacom.org/docs/default-source/presentations/student-guide-for-web-5-28-19.pdf?sfvrsn=4aab3d97_2 (Accessed July 2, 2019).
3. Consumer Information and Student Achievement Guide 2017-2018. Ponce Health Sciences University. Available at: https://www.psm.edu/wp-content/uploads/2016/09/Ponce-Health-Sciences-University-Consumer-Information-and-Student-Achievement-Guide.pdf (Accessed July 2, 2019).
4. California Northstate University Fact Book, 2017-2018. California Northstate University. Available at: https://www.cnsu.edu/shareddocs/Fact-Book-2017-2018.pdf (Accessed July 2, 2019).
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6. Burrell College of Osteopathic Medicine Institutional Snapshot. Burrell College of Osteopathic Medicine. Available at: https://bcomnm.org/wp-content/uploads/2019/05/Institutional-Snapshot.pdf (Accessed July 2, 2019).
7. Idaho College of Osteopathic Medicine. About ICOM. Available at: https://www.idahocom.org/ (Accessed July 2, 2019).

APPENDIX B
TABLE 2. FINANCIAL BURDEN OF NON-GRADUATES VERSUS GRADUATES OF U.S. MEDICAL SCHOOLS

Not-for-profit	***Financial Burden***
U.S. allopathic medical schools	In 2018-2019, the median annual tuition and fees at state medical schools were $38,202; at private medical schools the median cost was $61,533.[6] In 2019, for students who attended state medical schools the median debt was $190,000; for students who attended private medical schools the median debt was $210,000.[1]
U.S. osteopathic medical schools	The overall mean osteopathic medical education debt reported for academic year 2017-2018 graduates is $254,953 ($222,972 for public schools and $261,133 for private schools).[2]
For-profit*	***Financial Burden***
Ponce Health Sciences University School of Medicine	4-year estimated tuition, fees and costs range from $233,456 to $342,069.[3]
California Northstate University College of Medicine	4-year estimated tuition, fees, and costs range from $240,000 to $255,000.[4]
Rocky Vista University College of Osteopathic Medicine	4-year estimated tuition, fees, and cost are $215,748; typical graduate leaves with $294,018 in debt.[5]
Burrell College of Osteopathic Medicine at New Mexico State University**	2018-2019 annual cost of attendance is $80,165.[6]
Idaho College of Osteopathic Medicine**	2018-2019 academic year annual tuition is $49,750 plus $2,500 in fees.[7]
California Health Sciences University College of Osteopathic Medicine**	Fall 2020 enrollment annual cost of tuition is $53,500.[8]

**Data not available from offshore medical schools*
***Data on student debt for newer U.S. medical schools are not yet available*

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APPENDIX C
AMA POLICY

D-305.954, "For-Profit Medical Schools or Colleges"
Our AMA will study issues related to medical education programs offered at for-profit versus not-for-profit medical schools, to include the: (a) attrition rate of students; (b) financial burden of non-graduates versus graduates; (c) success of graduates in obtaining a residency position; and (d) level of support for graduate medical education; and report back at the 2019 Annual Meeting.
(Res. 302, A-18)

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.
(CME Rep. A, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Res. 313, I-95 Reaffirmed by CME Rep. 13, A-97 Modified: CME Rep. 7, A-05 Modified: CME Rep. 13, A-06 Appended: Res. 321, A-15 Reaffirmed: CME Rep. 05, A-16 Modified: CME Rep. 04, A-16)

H-305.925, "Principles of and Actions to Address Medical Education Costs and Student Debt"
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the 20/220 pathway, and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. 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).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar 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 federal Direct Loan Consolidation program, including the ability to lock in a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. 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.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physician s training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in 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; (i) 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.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
(CME Report 05, I-18 Appended: Res. 953, I-18 Reaffirmation: A-19)

H-200.949, "Principles of and Actions to Address Primary Care Workforce"
1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and

enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution s mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice

in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.
17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.
18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.
19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.
20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.
21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.
22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.
23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.
24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.
25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.
(CME Rep. 04, I-18)

D-295.309, "Promoting and Reaffirming Domestic Medical School Clerkship Education"
1. Our American Medical Association:
A. Will work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: (1) infrastructure and faculty development and capacity for medical school expansion; and (2) delivery of clinical clerkships and other educational experiences.
B. Encourages clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students.
C. Advocates for federal and state legislation/regulations to: (1) Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA); (2) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and (3) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality,

curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA.
D. Encourages relevant stakeholders to study whether the public service community benefit commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level.
E. Will work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students.
2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution s own students educationally and/or financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites.
3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas.
4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA.
5. AMA policy is that existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.
(CME Rep. 01, I-17)

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-19

Subject: Healthcare Finance in the Medical School Curriculum (Resolution 307-A-18)

Presented by: Jacqueline A. Bello, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 307-A-18, "Healthcare Finance in the Medical School Curriculum," introduced by the Missouri Delegation and referred by the American Medical Association (AMA) House of Delegates (HOD), asks that the AMA "study the extent to which medical schools and residency programs are teaching topics of healthcare finance and medical economics" and "make a formal suggestion to the Liaison Committee on Medical Education encouraging the addition of a new Element, 7.10, under Standard 7, 'Curricular Content,' that would specifically address the role of healthcare finance and medical economics in undergraduate medical education."

During the 2018 Annual Meeting, Reference Committee C heard mixed testimony on this item. It was noted that health care finance is already being taught in some medical schools, but an overall understanding of the breadth, depth, and frequency of these offerings is unknown. Furthermore, concern was expressed that the second Resolve implied a curricular mandate in an already distended medical education curriculum. The reference committee believed that additional study was warranted; the HOD agreed, and this item was referred. This report addresses that referral.

BACKGROUND AND DATA

The United States spends more on health care than any other nation in the world, with health care expenditures at 17.9 percent of gross domestic product in 2017, and national health care spending is projected to increase at a rate of 5.5 percent per year for the next 10 years under current law. Multiple factors contribute to the high cost of health care in the United States, including costs for labor and goods, pharmaceutical costs, administrative costs.[1,2,3] Numerous studies have found that while cost of care in the U.S. is often double that of other industrialized countries, outcome measures are essentially the same. In recognition of this concern, reducing cost of care is one of the Triple Aims of the Institute for Health Care Improvement and one of the three core aims of health care reform.[4]

The medical education system has been shown to favorably impact cost of care by medical school graduates who have had cost, financing, and medical economics topics integrated into their respective program curricula. Chen et al.[5] found that the spending pattern of the training location was positively associated with care expenditures when the residents entered practice, implying that interventions in training may have the potential to reduce health care spending after completion of training. Phillips et al.[6] similarly found that family physician and general internist spending was influenced by location of training in low, average, or high-cost locations, and concluded, "The 'imprint' of training spending patterns on physicians is strong and enduring, without discernible

quality effects…" Stammen et al.[7] in a published systematic review on the effectiveness of medical education on high-value, cost-conscious care, reached the following conclusion:

> … learning by practicing physicians, resident physicians, and medical students is promoted by combining specific knowledge transmission, reflective practice, and a supportive environment. These factors should be considered when educational interventions are being developed.

Curriculum content in health care financing is currently required by the accrediting body for allopathic medical schools in the United States, the Liaison Committee on Medical Education (LCME). The LCME's accreditation *Standard 7: Curricular Content* requires that "the medical school curriculum provides content of sufficient breadth and depth to prepare medical students for entry into any residency program and for the subsequent contemporary practice of medicine." This requirement is expressed through *Element 7.1: Biomedical, Behavioral, and Social Sciences* by ensuring that "the medical curriculum includes content from biomedical, behavioral, and socioeconomic sciences to support medical students' mastery of contemporary scientific knowledge and concepts and the methods fundamental to applying them to the health of individuals and populations."[8] As part of their accreditation documents, schools are asked to document where in the curriculum health care financing is taught (preclinical or clinical phases), but schools are not asked to comment on the content or quantity of the subject matter. The quality of instruction and educational materials is not evaluated. No inquiries are made regarding medical economics.[9]

Unrelated to the accreditation process, each year the LCME requests that schools complete a voluntary survey, the LCME Annual Medical School Questionnaire Part II. The questionnaire includes queries on where in the curriculum certain topics are taught. Data relevant to this report from academic years 2013-14 through 2017-18 are provided in the tables below.

Health Care Financing*/Cost of Care#					
Survey year	Total number of schools surveyed	Location in curriculum			
		Required Course	Elective	Pre-clerkship	Clerkships
2017-18*	147	131	63	120	89
2016-17#	145	140	72	128	97
2015-16#	142	137	67	120	125
2014-15*	141	140	61	127	112
2014-15#	141	139	84	120	112
2013-14*	140	133	64	120	108
2013-14#	140	129	53	112	103

* Survey item was "health care financing"
\# Survey question was "cost of care"
2013-14 and 2014-15 surveys included both terms

Medical Socioeconomics*/Medical Economics#					
Survey year	Total number of schools surveyed	Location in curriculum			
		Required Course	Elective	Pre-clerkship	Clerkships
2017-18*	147	143	79	141	117
2017-18#	147	135	85	132	105
2016-17*	145	136	84	129	105
2016-17#	145	141	77	136	112
2015-16#	142	132	71	123	107

2015-16*	142	138	72	131	110
2014-15*	141	137	96	128	116
2013-14*	140	133	60	125	106

* Survey item was "medical socioeconomics"
# Survey question was "medical economics"
2015-16, 2016-17, and 2017-18 surveys included both terms

For 2016-17 and 2017-18, schools were also asked where in the curriculum the specific topics were covered to prepare students for entry into residency training.

Health system content (e.g., health care financing, billing, coding)					
Survey year	Total number of schools surveyed	Location in curriculum			
		4th year transition to residency course	Required sub-internship	Required 3rd year clinical clerkship	Intersession
2017-18	147	67	42	80	42
2016-17	145	82	51	93	52

The accreditation standards of the Commission on Accreditation of Osteopathic Colleges (COCA) do not explicitly state a requirement for curriculum related to medical economics or health care financing.[10]

The Accreditation Council for Graduate Medical Education common program requirements IV.B.1.f).(1).(f) and (g) require residents to demonstrate competence in "incorporating considerations of value, cost awareness, delivery and payment…" and "understanding health care finances and its impact on individual patients' health decisions." [11] A limited review of specialty-specific milestones, the mechanism by which residents are assessed for achievement of competency, revealed that family medicine, internal medicine, emergency medicine, and diagnostic radiology have milestones that assess residents' competency in delivering cost-conscious care, cost-effective care, or consideration of health care costs.[12]

CURRENT INITIATIVES

Despite the UME and GME requirements noted above, there has been a growing realization of the need for additional training in health systems, including health care financing and medical economics during UME. To address this concern, the concept of health systems science (HSS) has recently taken hold as a "third pillar" of medical education[13] (basic science and clinical science being the traditional two pillars). In recognition of the need to change the medical education system to train physicians in HSS, the AMA funded the Accelerating Change in Medical Education initiative, with the goal of enhancing medical school curricula to better train future physicians in the competencies needed to provide high quality care in health systems. HSS curriculum, which includes medical economics content, is a focus of the initiative. A tangible outcome from the consortium was the publication of the first HSS textbook.[14] The initial 11-school consortium has grown to 37 schools. The AMA also supports a learning module, "Health Care Delivery Systems - AMA Health Systems Science Learning Series," through the AMA Ed Hub.[15] In addition, through its GME Competency Education Program (GCEP), the AMA offers a series of online educational modules designed to complement teachings in residency and fellowship programs, with a library of more than 30 individualized courses designed for self-paced learning. One content area of the

module is how payment models affect patient care and costs. A study of consortium schools found that health care economics and value-based care are core domains of their HSS curricula.[16]

The inclusion of UME curricular content on HSS in general, and health care financing specifically, has been advanced by the inclusion of these topics on standardized examinations. The United States Medical Licensing Examination (USMLE) Content Outline website lists health care economics, health care financing, high value/cost-conscious care, and relevant subtopics as content areas across all USMLE examinations.[17] A case-based review book on HSS has been developed by the ACE consortium as a review tool on HSS topics covered on the USMLE examinations.[18] The review book includes a chapter of cases and questions on health care economics.[19] To further support HSS assessment at the UME level, a pilot subject examination in HSS has been developed by a consortium of medical schools in collaboration with the National Board of Medical Examiners.[20]

RELEVANT AMA POLICY

H-295.924, "Future Directions for Socioeconomic Education" (Modified and reaffirmed 2017)

> The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum.

D-295.321, "Health Care Economics Education" (Modified and reaffirmed 2015)

> Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physician's professional life, starting in undergraduate medical education, graduate medical education and continuing medical education.

H-295.977, "Socioeconomic Education for Medical Students" (Modified 2010)

> 1. The AMA favors (a) continued monitoring of U.S. medical school curricula and (b) providing encouragement and assistance to medical school administrators to include or maintain material on health care economics in medical school curricula.
> 2. Our AMA will advocate that the medical school curriculum include an optional course on coding and billing structure, RBRVS, RUC, CPT and ICD-9.

H-295.864, "Systems-Based Practice Education for Medical Students and Resident/Fellow Physicians" (Modified and reaffirmed 2017)

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

SUMMARY AND RECOMMENDATIONS

The academic literature suggests that education and role-modeling have an effect on the cost-effectiveness of care provided by graduates of programs that emphasize cost considerations in education of physicians. Curriculum content on health care financing/medical economics is required by the accrediting bodies for allopathic medical schools and GME programs. With few exceptions, allopathic medical schools report the inclusion of the topics of health care financing, health care costs, medical socioeconomics, and medical economics in their respective curricula. Several of the larger GME specialty milestones require cost considerations in the training curricula. The exact content and amount of curricular time devoted to these topics at individual schools and GME programs is unknown. The AMA provides online educational resources on HSS topics, including the effect of payment models on health outcomes and cost of care, and the AMA-supported Accelerating Change in Medical Education initiative includes medical economics in the focus area of HSS. USMLE Step exams include questions on health care economics, and a subject exam focusing on HSS has been developed. The AMA has existing policy encouraging medical schools and residency programs to include health care finance and medical economics in their respective curricula while avoiding curricular mandates.

Related to Resolution 307-A-18, its first directive (that the AMA "study the extent to which medical schools and residency programs are teaching topics of healthcare finance and medical economics") has been addressed through this report.

The resolution also asks that the AMA "make a formal suggestion to the Liaison Committee on Medical Education encouraging the addition of a new Element, 7.10, under Standard 7, 'Curricular Content,' that would specifically address the role of healthcare finance and medical economics in undergraduate medical education." To address this aspect, amendments to Policy H-295.924, "Future Directions for Socioeconomic Education," are proposed below. The rationale for each edit is as follows:

- GME programs, not medical schools, are responsible for graduate medical education. Most GME programs are not under the direct authority of medical schools. Adding "and

residencies" to item 2 of this policy clarifies the responsibility and authority for oversight of graduate medical education and curricular content.

- Historically, the AMA has refrained from curricular mandates, especially mandates with this degree of specificity. Similarly, the LCME has been disinclined to accept recommendations with curricular mandates. Eliminating the phrase "in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings" allows for more flexibility to medical schools and residency programs in implementation of this curricular content.

- The AMA does not have "representatives" on the LCME. Some LCME members are nominated by the AMA for consideration as professional members of the LCME, but, if elected by the LCME, they do not represent the AMA. Their fiduciary responsibility while serving as a member of the LCME is to the LCME. DOE regulations require separation of the accrediting agency from direct sponsor influence.

The Council on Medical Education therefore recommends that the following recommendation be adopted in lieu of Resolution 307-A-18 and the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-295.924, "Future Directions for Socioeconomic Education," by addition and deletion to read as follows:

"The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented ~~in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings,~~ at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage ~~representatives to~~ the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum." (Modify Current HOD Policy)

Fiscal note: $500.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 4-I-19

Subject: Board Certification Changes Impact Access to Addiction Medicine Specialists (Resolution 314-A-18)

Presented by: Jacqueline A. Bello, MD, Chair

Referred to: Reference Committee C

Resolution 314-A-18, "Board Certification Changes Impact Access to Addiction Medicine Specialists," introduced by the Michigan Delegation and referred by the American Medical Association (AMA) House of Delegates (HOD), asks:

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

This resolution was referred due to mixed testimony about the new requirements for ABMS subspecialty board certification in addiction medicine and concerns centered around the equivalency of ABAM and ABMS board certifications. Although a number of physicians have held ABAM certification, they do not meet the requirements for ABMS subspecialty certification in addiction medicine if they do not hold current ABMS certification in a primary specialty. Although specialty board certification is not required to practice medicine, it may be needed to meet the credentialing requirements of hospitals.

This report calls attention to the urgent need to train physicians in addiction medicine, provides background information on the process for obtaining subspecialty board certification in addiction medicine, and provides an update on the time-limited pathway for subspecialty certification in addiction medicine for ABAM diplomates.

BACKGROUND

More than 20 million Americans need treatment for substance use disorder, and 2 million Americans have an opioid use disorder.[1-2] However, only 3,500 U.S. physicians (approximately) are trained in addiction medicine to meet this need.[2] Although medical schools and teaching hospitals are actively working to address the crisis in their communities, more physicians need to be trained in addiction medicine to address this public health challenge.

Since 2008, the ABAM, a non-ABMS member board, has offered certification and recertification in addiction medicine. ABAM certification is valid as long as ABAM diplomates maintain enrollment in the ABAM Maintenance of Certification program.[3] In October 2015, the new subspecialty of addiction medicine, sponsored by the American Board of Preventive Medicine (ABPM), was recognized by the ABMS.[4] In June 2016, fellowship training in addiction medicine was approved by the Accreditation Council for Graduate Medical Education (ACGME).

In 2017, the ABPM began offering physicians the opportunity to become certified in the subspecialty of addiction medicine, and physicians certified by any of the ABMS member boards have been eligible to apply. During the first five years (2017-2021) the addiction medicine examination is given, individuals may become qualified by the Practice Pathway (through which physicians can meet eligibility requirements for certification in addiction medicine without completing an addiction medicine fellowship). In order to meet the requirements for ABPM subspecialty certification in addiction medicine, physicians who do not hold ABAM certification must also hold a current ABMS certification in any primary specialty to meet the requirements for ABPM subspecialty certification in addiction medicine.

ABPM PATHWAYS AVAILABLE TO ACHIEVE SUBSPECIALTY CERTIFICATION IN ADDICTION MEDICINE

There are multiple pathways to achieve subspecialty certification in addiction medicine through the ABPM, as described below.[5]

Practice Pathway

- Time in Practice

  Applicants must submit documentation of a minimum of 1,920 hours in which they were engaged in the practice of addiction medicine at the subspecialty level; this minimum of 1,920 hours must have occurred over at least 24 of the previous 60 months prior to application. The minimum of 24 months of practice time need not be continuous; however, all practice time must have occurred in the five-year period preceding June 30 of the application year. Practice must consist of broad-based professional activity with significant addiction medicine responsibility. Applicants must also demonstrate a minimum of 25 percent (or 480 hours) as direct patient care. Addiction medicine practice outside of direct patient care, such as research, administration, and teaching activities, may count for a combined maximum of 75 percent (or 1,440 hours). Only 25 percent (480 hours) of general practice can count towards the required hours for the Practice Pathway, and the remaining 75 percent must be specific addiction medicine practice. Fellowship activity that is less than 12 months in duration or non-ACGME accredited may be applied toward the practice activity requirement. The actual training must be described for any fellowship activity.

  Documentation of addiction medicine teaching, research, and administration activities, as well as clinical care or prevention of, or treatment of, individuals who are at risk for or have a substance use disorder may be considered.

- Non-accredited fellowship training

  Credit for completion of training in a non-ACGME-accredited fellowship program may be substituted for the Time in Practice hour requirements of the Practice Pathway. To qualify, the applicant must have successfully completed a non-ACGME-accredited addiction medicine fellowship of at least 12 months that is acceptable to the ABPM. The fellowship training curriculum as well as a description of the actual training experience must also be submitted to the ABPM for its review and consideration.

  Fellowship training of less than 12 months in a non-ACGME accredited program may be applied towards the Time in Practice hour requirements of the Practice Pathway.

ABAM Diplomate Pathway (available through 2021)

Applicants holding certification by ABAM must meet the medical licensure and ABPM certification requirements to be considered for the addiction medicine subspecialty examination. Documentation of current ABAM diplomate status may be submitted in place of practice time documentation and required attestation of clinical competence. (ABAM diplomates are required to maintain certification through ABAM's Transitional Continuous Certification [TraCC] Program. Diplomates who passed ABAM's certifying exam in 2015 or who recertified by passing ABAM's recertifying exam in 2015 may be qualified to expedite the certification process with the ABPM.)

ABAM diplomates certified, or recertified, in 2015 must submit formal application through the ABAM diplomate pathway and be accepted by the ABPM. Only then may their ABPM certifying exam be waived and certification conferred following usual procedures, with an effective date of January 1 of the year following the ABPM's approval of the formal application.

The Addiction Medicine ABAM Diplomate Pathway will expire in 2021. Beginning in 2022, all applicants for ABPM certification in addiction medicine must successfully complete an ACGME-accredited addiction medicine fellowship program.

ACGME-accredited Fellowship Pathway

Applicants must successfully complete a minimum of 12 months in an ACGME-accredited addiction medicine fellowship program. If the program is longer than 12 months, the physician must successfully complete all years of training for which the program is accredited in order to meet the eligibility criteria for certification in addiction medicine.

THE ABMS COMMITTEE ON CERTIFICATION (COCERT) APPROVED SPECIFIC, TIME-LIMITED PATHWAY FOR SUBSPECIALTY CERTIFICATION IN ADDICTION MEDICINE FOR ABAM DIPLOMATES

In 2018, the ABPM, in collaboration with the American Society of Addiction Medicine, submitted a request to ABMS to expand the eligibility requirements for the ABPM's Addiction Medicine subspecialty.[6] The ABPM's request was limited in time to include a period beginning on January 1, 2019 and ending at the conclusion of the 2021 exam cycle on December 31, 2021. In March 2019, the ABMS Committee on Certification (COCERT) approved the ABPM's request to expand eligibility to include physicians certified by ABAM, current with the ABAM's TraCC Program, and who previously possessed underlying primary certification from an ABMS member board but allowed that certification to lapse because addiction medicine became the primary area of the physician's practice.

The proposed expansion excluded physicians who never obtained primary ABMS member board certification, who lost ABMS member board certification as a result of a disciplinary action, or who may have surrendered a medical license in lieu of or otherwise to avoid the possibility of disciplinary action.

DIPLOMATES CERTIFIED BY THE ABPM IN ADDICTION MEDICINE NO LONGER REQUIRED TO MAINTAIN PRIMARY CERTIFICATION TO RECERTIFY IN ADDICTION MEDICINE

Previously, the ABMS approved ABPM's request that diplomates certified by the ABPM in addiction medicine will no longer be required to maintain primary ABMS member board

certification in order to recertify. With this policy change, diplomates certified by the ABPM in addiction medicine may recertify their ABPM subspecialty certificate in addiction medicine without the need to maintain primary ABMS member board certification.

RELEVANT AMA POLICY

It is the policy of the AMA to encourage all physicians, particularly those in primary care fields, to undertake education in treatment of substance use disorder. The AMA also supports the new ABMS-approved multispecialty subspecialty of addiction medicine, which offers certification to qualified physicians who are diplomates of any of the 24 ABMS member boards and the ABPM certification examination in addiction medicine. AMA policies related to addiction medicine and specialty board certification are shown in the Appendix.

DISCUSSION

There is a significant shortage of qualified addiction physicians in the United States, and physicians from a variety of disciplines (e.g., internal medicine, family medicine, pediatrics) are needed.[7] Expanding the ABPM pathway will assist in growing the addiction medicine workforce at a time when the treatment of opioid addiction is a national public health crisis and there is a spectrum of medical problems associated with substance use disorders.[7]

The ABPM pathway runs through an examination and not through any "deeming" or general recognition of equivalency of any board outside the ABMS member board community. Thus, individuals will be required to demonstrate to the ABPM that they possess the "knowledge, clinical skills, and professionalism" to practice safely in the discipline of addiction medicine in order to be granted a certificate from this ABMS member board. Physicians who choose to become certified in the new subspecialty may qualify to take the addiction medicine exam by meeting time-in-practice and other eligibility requirements, but will not be required to complete specialized fellowship training at this time. However, in 2022 the ABPM will require physicians to complete an ACGME-accredited program. The ACGME has accredited 62 twelve-month addiction medicine fellowship programs, with plans to increase the number of programs to 125.[8] Education in addiction medicine is also becoming a viable choice for medical students and residents.[9]

The American Osteopathic Association (AOA) has also created a mechanism to allow osteopathic physicians (DOs) with an active primary AOA board certification and ABAM certification to be granted AOA subspecialty certification in addiction medicine.[10] Osteopathic physicians will be required to maintain such certification through the AOA's addiction medicine osteopathic continuous certification process.[10]

SUMMARY AND RECOMMENDATIONS

The Council on Medical Education has been committed to working with the ABMS and the ABPM to ensure that all qualified physicians are offered pathways to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine in order to improve access to care for patients with substance use disorder.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 314-A-18 and the remainder of the report be filed.

1. That our American Medical Association (AMA) recognize the American Board of Preventive Medicine (ABPM) for developing and providing pathways for all qualified physicians to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine, in order to improve access to care for patients with substance use disorder. (Directive to Take Action)

2. That our AMA rescind Policy H-300.962 (3) "Recognition of Those Who Practice Addiction Medicine," since the ABPM certification examination in addiction medicine is now offered. (Rescind HOD Policy)

Fiscal Note: $500.

APPENDIX

H-300.962, "Recognition of Those Who Practice Addiction Medicine"
1. It is the policy of the AMA to: (a) encourage all physicians, particularly those in primary care fields, to undertake education in treatment of substance abuse; (b) direct its representatives to appropriate Residency Review Committees (RRCs) to ask the committees on which they serve to consider requiring instruction in the recognition and management of substance abuse. Those RRCs that already require such instruction should consider greater emphasis for this subject. (c) encourage treatment of substance abuse as a subject for continuing medical education; and (d) affirm that many physicians in fields other than psychiatry have graduate education and experience appropriate for the treatment of substance abuse, and for utilization review, and for other evaluation of such treatment, and should be entitled to compensation.
2. Our AMA commends the American Board of Preventive Medicine (ABPM) for its successful application to the American Board of Medical Specialties (ABMS) to establish the new ABMS-approved multispecialty subspecialty of addiction medicine, which will be able to offer certification to qualified physicians who are diplomates of any of the 24 ABMS member boards.
3. Our AMA encourages the ABPM to offer the first ABMS-approved certification examination in addiction medicine expeditiously in order to improve access to care to treat addiction.
(CME Rep. I-93-5 Reaffirmed: CME Rep. 10, I-98 Reaffirmed: CME Rep. 11, A-07 Appended: Res. 314, A-16)

Policy H-275.924 (15), "Continuing Board Certification"
15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

H-275.926, "Medical Specialty Board Certification Standards"
Our AMA:
1. Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, be utilized for that determination.
3. Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
4. Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
5. Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
(Res. 318, A-07 Reaffirmation A-11 Modified: CME Rep. 2, I-15)

D-120.985, "Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone"
1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.
2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management.
3. Our AMA will work in conjunction with the Association of American Medical Colleges, American Osteopathic Association, Commission on Osteopathic College Accreditation, Accreditation Council for

Graduate Medical Education, and other interested professional organizations to develop opioid education resources for medical students, physicians in training, and practicing physicians.
(Sub. Res. 508, A-03 Reaffirmed: CSAPH Rep. 1, A-13 Appended: Res. 515, A-14 Reaffirmed: BOT Rep. 14, A-15 Appended: Res. 311, A-18 Reaffirmation: A-19)

H-310.906, "Improving Residency Training in the Treatment of Opioid Dependence"
Our AMA: (1) encourages the expansion of residency and fellowship training opportunities to provide clinical experience in the treatment of opioid use disorders, under the supervision of an appropriately trained physician; and (2) supports additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the treatment of opioid use disorders.

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 5-I-19

Subject: The Transition from Undergraduate Medical Education to Graduate Medical Education

Presented by: Jacqueline A. Bello, MD, Chair

INTRODUCTION

A critical step in the development of a physician is the transition from undergraduate medical education (UME), or medical school, to graduate medical education (GME), or residency training. Ensuring a seamless transition supports learners' well-being and their readiness to take on and master the many challenges in their chosen field of medicine. In addition, patient safety in our nation's teaching hospitals is paramount in the public eye, as evidenced by coverage of the "July Effect" in the media. This underscores the need for preparedness among first-year resident physicians as well as the need for a highly effective, efficient, and supportive educational environment.

The American Medical Association (AMA) has taken a lead role to address these issues and call for medical education to "mind the gap" between the various stages of medical education—in particular, the UME to GME transition—in part through its Accelerating Change in Medical Education initiative and Reimagining Residency initiative, as described in this report. The AMA is working to help smooth the transition from UME to GME as part of its effort to encourage innovation in the development of medical students, trainees, and physicians throughout their career. This report also provides relevant AMA policy on this topic (see the Appendix).

MEDICAL SCHOOL PREPARATION OF GRADUATES FOR RESIDENCY

One body of data that measures medical student preparedness for entry into residency is the Association of American Medical Colleges' (AAMC) Graduation Questionnaire (GQ), a national questionnaire administered to graduates of U.S. MD-granting medical schools accredited by the Liaison Committee on Medical Education (LCME).[1] The GQ is an important tool for medical schools to use in program evaluation and to improve the medical student experience.

The AAMC's All Schools Summary Report for 2018[2] includes GQ data for the five-year period 2014 to 2018. Eighty-three percent (16,223) of medical school graduates in academic year 2017-2018 (19,537) participated in the 2018 GQ.

Question 12 of the questionnaire asks respondents, "Indicate whether you agree or disagree with the following statements about your preparedness for beginning a residency program." Averaging the data for the five-year period (2014 to 2018) produces the following numbers. In the right-hand column, the percentages from the "Agree" and "Strongly agree" fields are combined; the table is sorted based on this variable, which ranges from a high of 98.3 percent ("I have the communication skills necessary to interact with patients and health professionals") to 90.2 percent ("I am confident that I have acquired the clinical skills required to begin a residency program").

Percentage of Respondents Selecting Each Rating					
Strongly disagree	**Disagree**	**Neutral**	**Agree**	**Strongly agree**	**Total: Agree and Strongly agree**
I have the communication skills necessary to interact with patients and health professionals.					
0.2	0.2	1.4	26.2	72.1	98.3
I understand the ethical and professional values that are expected of the profession.					
0.2	0.2	1.5	29.9	68.2	98.1
I believe I am adequately prepared to care for patients from different backgrounds.					
0.3	0.6	3.4	35.9	59.9	95.8
I have basic skills in clinical decision making and the application of evidence based information to medical practice.					
0.3	0.7	4.7	46.2	48.2	94.4
I have a fundamental understanding of the issues in social sciences of medicine (e.g., ethics, humanism, professionalism, organization and structure of the health care system).					
0.3	1.0	4.9	40.9	52.8	93.7
I have the fundamental understanding of common conditions and their management encountered in the major clinical disciplines.					
0.3	1.0	5.2	52.0	41.5	93.5
I am confident that I have acquired the clinical skills required to begin a residency program.					
0.5	1.9	7.4	47.9	42.3	90.2

Another assessment of medical schools' efforts in preparing medical students for residency is the LCME's Annual Medical School Questionnaire Part II.

Particularly relevant to this report are data from the question, "Indicate where in the curriculum the following topics to specifically prepare students for entry to residency training are covered" (question 19 for the 2018-2019 questionnaire). Aggregate data for 151 medical schools are shown, sorted by the sum of the numbers for the five places in the curriculum where the specific topic is taught, as shown in the right-hand column.

Topic	**Required 4th Year Transition to Residency Course**		**Required Sub-internship**	**Required 3rd Year Clinical Clerkship**	**Inter-session in 3rd or 4th Year**	**Total**
	Specialty-specific	**One course for all students**				
Training in clinical procedures	55	57	105	135	51	403
Disease management (general or specialty-specific)	44	53	124	140	30	391
Working in teams	32	76	105	124	53	390
Working with the EHR/health records	22	43	110	135	48	358
Hand-off procedures	35	68	100	93	28	324

Patient safety/reporting medical errors	16	77	70	104	51	318
Advanced communication skills	26	68	84	85	44	307
Stress, wellness, and burnout in residency training	19	81	21	63	58	242
Health system content (e.g., team care, health care financing)	12	72	38	73	47	242
On-call emergencies	39	50	84	73	18	264
Experiencing the life of a resident (e.g., night call/float)	24	35	85	75	6	225
Medical regulatory content (e.g., licensure, discipline, DEA)	8	55	10	23	32	128
ACLS/ATLS training and certification	9	47	9	25	35	125

THE AMA'S ACCELERATING CHANGE IN MEDICAL EDUCATION AND REIMAGING RESIDENCY INITIATIVES

Phase one of the AMA's Accelerating Change in Medical Education initiative, launched in 2013, was intended to:

> [F]oster… a culture of medical education advancement, leading to the development and scaling of innovations at the undergraduate medical education level across the country. After awarding initial grants to 11 U.S. medical schools, the AMA convened these schools to form the Accelerating Change in Medical Education Consortium—an unprecedented collective that facilitated the development and communication of groundbreaking ideas and projects. The AMA awarded grants to an additional 21 schools in 2016. Today, almost one-fifth of all U.S. allopathic and osteopathic medical schools are represented in the 32-member consortium [expanded to 37 schools in 2019], which is delivering revolutionary educational experiences to approximately 19,000 medical students—students who one day will provide care to a potential 33 million patients annually.[3]

Building upon that impetus, in early 2019 the AMA established the Reimagining Residency initiative—a five-year, $15 million grant program to address challenges associated with the transition from UME to GME and the maintenance of progressive development through residency and across the continuum of physician training. Grants are intended to promote systemic change in GME and support bold, creative innovations that establish new curricular content and experiences to enhance readiness for practice, support well-being in training, and (of particular relevance to this report) provide a meaningful and safe transition from UME to GME. Learn more at: ama-assn.org/education/improve-gme/ama-reimagining-residency-initiative.

Included in the Accelerating Change in Medical Education and Reimagining Residency initiatives are grantees that are focusing on the UME/GME transition. For example, at Florida International University (FIU) Herbert Wertheim College of Medicine, readiness for residency is monitored by way of competency-based assessments using the Entrustable Professional Activities (EPAs).

As an awardee for both the UME and GME phases of the AMA's grants, New York University Langone School of Medicine is using its latest grant to further its coaching experience through the "NYU Transition to Residency Advantage." The goal of this work is to "enhance the transition from UME to GME through robust coaching, individualized pathways, and enhanced assessment

tools to enable GME programs to shift away from one-size-fits-all education."[4] Similarly, the University of North Carolina School of Medicine received funding from the Reimagining Residency initiative for Fully Integrated Readiness for Service Training (FIRST): Enhancing the Continuum from Medical School to Residency to Practice. Its goals include "implementing a generalizable health systems science curriculum for GME and competency-based assessment tools that span the educational continuum."[5] In addition, the Association of Professors of Gynecology and Obstetrics received a planning grant for its "Right Resident, Right Program, Ready Day One" project, intended to transform the UME to GME transition for residents entering obstetrics and gynecology programs.

CHALLENGES TO CHANGE

As noted in the introduction, certain innovations that improve the transition from UME to GME may challenge existing processes/systems managed by organizations responsible for medical education accreditation, certification, licensing, and residency matching. For example, one of the innovations being studied in the AMA-led consortium is competency-based medical education, in which learners are advanced to the next level of training upon satisfactory demonstration of the requisite knowledge and skills, versus a strictly time-based system that treats all learners alike. Despite the considerable value of this new paradigm from the learner perspective, it may present hurdles to the system of medical education accreditation, funding, and certification and further inhibit (at least in the short run) the development of a smoother UME/GME transition.

Another concern, which relates to the match into residency, is the growing number of residency program applications being submitted by applicants. This is due, in part, to a growing number of medical school graduates in the U.S. and concerns among residency applicants about limited availability of residency program slots. This issue is particularly pointed in competitive specialties. The increased number of applications is expensive and inefficient for applicants and burdensome for residency program directors and personnel, who must review and prioritize these applications. The rising volume of applications leads programs to employ applicants' scores on the United States Medical Licensing Examination (USMLE) for screening purposes, eliminating applications below a certain arbitrary line.

This process for applicant screening, while understandable given the circumstances, runs counter to AMA policy, which reflects the principle that "selection of residents should be based on a broad variety of evaluative criteria," and asks that ACGME requirements "state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection."[6] It also lessens the opportunity for holistic review of candidates, through which more intangible attributes and life experience are given equal (if not greater) weight than school grades and examination scores. Indeed, as noted by the authors of a recent perspective in *JAMA*, "the current USMLE 3-digit scores may be distracting the medical education system from the goal of building an innovative, diverse, and resilient physician workforce."[7]

Invitational Conference on USMLE Scoring (InCUS)

The AMA and other leading organizations in medical education convened an invitational conference in March 2019, the Invitational Conference on USMLE Scoring (InCUS), to explore issues around unintended uses of USMLE scores. As noted in a summary report and preliminary recommendations from the meeting, the general consensus among participants is that "[t]he current UME-GME transition system is flawed and not meeting the needs of various stakeholders. Over time, various stakeholder groups have tried to optimize the system for their own purposes, but this has left some, including applicants, with an undue burden and at worst negatively impacted

diversity."[8] One of the recommendations arising from the conference, also noted in the report, is to "[c]onvene a cross-organizational panel to create solutions for the assessment and transition challenges from UME to GME, targeting an approved proposal, including scope/timelines by end of calendar year 2019." As further noted in the report, these challenges would include "[r]educing the number of applications perceived by residency applicants as necessary to obtain a position," "[i]mproving Residency Program Directors' ability to more holistically evaluate candidates," and "[i]mproving the trust of school-based assessments for residency screening and selection."

During the ensuing public comment period, the Council on Medical Education developed and submitted comments on the InCUS recommendations; key points included the following:

- The overemphasis on USMLE performance in the residency application process is unacceptable; a single three-digit score detracts from learning and engaging fully in the medical student experience, and may inhibit schools' implementation of curricular innovation. A holistic approach to assessing applicants, in contrast, with attention given to life experience and emotional intelligence, among other qualities, allows for individual talents to emerge and minimizes the impact of any one point, and may help increase the number of successful applicants from racial/ethnic minority populations.

- Any changes made to the residency application process need to consider the alternative tools for evaluation that remain. Preclinical grades, clinical rotation evaluations, and school-based assessments such as the MSPE/Dean's letter all have considerable shortcomings. Equally problematic is reliance on the reputation of the medical school, which is often determined by research dollars, not the quality of the teaching. Removing the numerical score may discriminate against medical students from new and lesser known U.S. medical schools and U.S. students attending international schools.

- All stakeholders in the process will need to "give" something as part of this transition. For example, students will need to be limited on the number of applications they submit, accrediting bodies (e.g., ACGME, LCME) will need to prohibit the use of USMLE as a program-level metric, and we need to reexamine the Match to see if it is really meeting the current needs. For program directors, a move to pass/fail scores may increase the burden they face in evaluating an ever-growing number of candidates.

- The overarching goal of this work needs to be broadened beyond "to decrease reliance on the USMLE Step 1 score for residency screening" and more toward "to improve and enhance the holistic evaluation of resident applicants."

The dialogue leading to the Council's response encompassed a rich and robust exchange of viewpoints among Council members—reflecting the complexity of these issues and the multiple levers, processes, and people affected by "the system" (including, and most importantly, our patients). Through the Council on Medical Education and senior staff, the AMA will continue to monitor, provide feedback on, and report back to the HOD on the status of outcomes from InCUS.

Additional issues in the UME/GME transition were limned in a forum hosted by the Council on Medical Education during the AMA's 2019 Annual Meeting. These include:

For students:
- The need for honest self-reflection and assessment of strengths and weaknesses.
- The need for honest and effective coaching and mentoring.

For medical schools:

- The need for transparency, accuracy, and honesty in assessments of students.
- The need to balance the responsibility to students (to help them successfully match) with the responsibility to residency programs (to be honest about students' strengths and weaknesses).
- The fear of unsuccessful matches reflecting poorly on the institution.
- "Failure to fail" (that is, the failure to fail those students who should not be advanced).

For residency program directors:

- The need to provide feedback to schools about interns' performance.
- The growing popularity of the "residency boot camp" model (e.g., the Resident Prep Curriculum, a weeklong boot camp to help ease the transition into surgical residency[9]).
- The need for a more holistic review of applications and less reliance on USMLE scores.

Overall:

- Inadequacy of the medical student performance evaluation (MSPE) to distinguish among applicants to residency (in other words, the "Lake Wobegon" effect).
- The need to move beyond the UME, GME, and CME silos to the lifelong learning model.
- Consider high-frequency, low-stakes assessment models, to look at a learner's real-time, cumulative trajectory of growth in knowledge, clinical skills, and professionalism.
- Multiple "scouts" evaluating performance in many types of venues/situations (not just clinical), to average out multiple direct observations.
- The need for free flow of information (in particular, the "right" information—i.e., that which is insightful, without being overwhelming, such that the signal to noise ratio becomes weak).
- Lack of trust among all parties and "gaming" the system; the match process, by its very nature, encourages masking faults and flaws. "Warm handoffs" may help increase trust in the system.

ENTRUSTABLE PROFESSIONAL ACTIVITIES

One framework that may provide a more useful assessment of learners to improve the UME/GME transition are the Core Entrustable Professional Activities (EPAs) for Entering Residency of the AAMC. The EPAs "provide expectations for both learners and teachers that include 13 activities that all medical students should be able to perform upon entering residency, regardless of their future career specialty. The guidelines are based on emerging literature documenting a performance gap at the transition point between medical school and residency training."[10]

SUMMARY

The AMA has taken a lead role in improving and easing the transition from UME to GME for learners, program directors, and patients alike. The process has a wide array of variables and stakeholders. Chief pain points are students submitting an inordinate and increasing number of applications in an attempt to match into programs in their chosen fields, and the (mis)use of USMLE Step 1 scores as a primary screening criterion for interviews. The complexity of the issue demands a wide-ranging solution. Through InCUS and related work, such as the Reimagining Residency initiative, the AMA is working to encourage a transition of the residency application/matching system towards a more holistic evaluation of applicants' full range of competencies and traits that would provide a broader assessment of a student's capabilities and "fit" with a program. In addition, through its Council on Medical Education and its ability to convene key stakeholders involved in medical education, the AMA will continue working to ensure that new residents are ready to undertake the rigors of residency from day one and learn (under supervision) how to serve their patients, from both an individual and a population perspective.

APPENDIX: RELEVANT AMA POLICY

H-295.895, "Progress in Medical Education: Structuring the Fourth Year of Medical School"

It is the policy of the AMA that: (1) Trends toward increasing structure in the fourth year of medical school should be balanced by the need to preserve opportunities for students to engage in elective clinical and other educationally appropriate experiences.
(2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training.
(3) There should be a comprehensive assessment of clinical skills administered at a time when the results can be used to plan each student's fourth-year program, so as to remedy deficiencies and broaden clinical knowledge.
(4) Medical schools should develop policies and procedures to ensure that medical students receive counseling to assist them in their choice of electives.
(5) Adequate and timely career counseling should be available at all medical schools.
(6) The ability of medical students to choose electives based on interest or perceived academic need should not be compromised by the residency selection process. The American Medical Association should work with the Association of American Medical Colleges, medical schools, and residency program directors groups to discourage the practice of excessive audition electives.
(7) Our AMA should continue to work with relevant groups to study the transition from the third and fourth years of medical school to residency training, with the goal of ensuring that a continuum exists in the acquisition of clinical knowledge and skills.
(CME Rep. 1, I-98 Reaffirmed: CME Rep. 9, A-07 Reaffirmed: CME Rep. 01, A-17)

H-295.862, "Alignment of Accreditation Across the Medical Education Continuum"

1. Our AMA supports the concept that accreditation standards for undergraduate and graduate medical education should adopt a common competency framework that is based in the Accreditation Council for Graduate Medical Education (ACGME) competency domains.

2. Our AMA recommends that the relevant associations, including the AMA, Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), and American Association of Colleges of Osteopathic Medicine (AACOM), along with the relevant accreditation bodies for undergraduate medical education (Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation) and graduate medical education (ACGME, AOA) develop strategies to:
a. Identify guidelines for the expected general levels of learners' competencies as they leave medical school and enter residency training.
b. Create a standardized method for feedback from medical school to premedical institutions and from the residency training system to medical schools about their graduates' preparedness for entry.
c. Identify areas where accreditation standards overlap between undergraduate and graduate medical education (e.g., standards related to the clinical learning environment) so as to facilitate coordination of data gathering and decision-making related to compliance.
All of these activities should be codified in the standards or processes of accrediting bodies.

3. Our AMA encourages development and implementation of accreditation standards or processes that support utilization of tools (e.g., longitudinal learner portfolios) to track learners' progress in achieving the defined competencies across the continuum.

4. Our AMA supports the concept that evaluation of physicians as they progress along the medical education continuum should include the following: (a) assessments of each of the six competency domains of patient care, medical knowledge, interpersonal and communication skills, professionalism, practice-based learning and improvement, and systems-based practice; and (b) use of assessment instruments and tools that are valid and reliable and appropriate for each competency domain and stage of the medical education continuum.

5. Our AMA encourages study of competency-based progression within and between medical school and residency.
a. Through its Accelerating Change in Medical Education initiative, our AMA should study models of competency-based progression within the medical school.
b. Our AMA should work with the Accreditation Council for Graduate Medical Education (ACGME) to study how the Milestones of the Next Accreditation System support competency-based progression in residency.

6. Our AMA encourages research on innovative methods of assessment related to the six competency domains of the ACGME/American Board of Medical Specialties that would allow monitoring of performance across the stages of the educational continuum.

7. Our AMA encourages ongoing research to identify best practices for workplace-based assessment that allow performance data related to each of the six competency domains to be aggregated and to serve as feedback to physicians in training and in practice.
(CME Rep. 4, A-14 Appended: CME Rep. 10, A-15)

D-295.317, "Competency Based Medical Education Across the Continuum of Education and Practice"

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

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

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

H-275.953, "The Grading Policy for Medical Licensure Examinations"

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

request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.

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

4. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. (CME Rep. G, I-90 Reaffirmed by Res. 310, A-98 Reaffirmed: CME Rep. 3, A-04 Reaffirmed: CME Rep. 2, A-14 Appended: Res. 309, A-17 Modified: Res. 318, A-18 Appended: Res. 955, I-18)

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 6-I-19

Subject: Veterans Health Administration Funding of Graduate Medical Education (Resolution 954-I-18)

Presented by: Jacqueline A. Bello, MD, Chair

Referred to: Reference Committee C

INTRODUCTION

Resolution 954-I-18, introduced by the American Academy of Dermatology, American Society for Dermatologic Surgery Association, and American Society of Dermatopathology, asked that our American Medical Association (AMA):

1. Continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions;

2. Collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration (VHA) funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process; and

3. Oppose service obligations linked to VHA GME residency or fellowship positions, particularly for resident physicians rotating through the VA for only a portion of their GME training.

The AMA House of Delegates adopted Resolves 1 and 2; these were appended to Policy D-510.990, "Fixing the VA Physician Shortage with Physicians." Resolve 3, which was referred, is the topic of this report.

Testimony before the reference committee on this resolution was mixed. The AMA has long been an advocate for preservation and expansion of GME funding to mitigate projected physician shortages and ensure that positions are available for medical school graduates applying to residency programs. Currently, there are no residency completion service obligations for Veterans Administration (VA) residency programs. Furthermore, it was noted that all funding for residency/fellowship positions, whether from private, VA, and/or Centers for Medicare & Medicaid Services (CMS) sources, carries with it the expectation that residents/fellows perform service for patients during their years in the training program. In addition, the VA sponsors very few residency programs; most residents who train in a VA facility do so as part of their training, with other sites and institutions responsible for components of the residency or fellowship. Due to the complicated rules at institutions that sponsor residency programs related to full funding for a resident full-time employee, it was recommended that Resolve 3 be referred for further study.

BACKGROUND

The Department of Veterans Affairs (VA) has long supported the training of health care professionals as part of its mission. With very few exceptions, the VA does not sponsor and operate its own GME programs, but instead partners with teaching hospitals to provide rotations in VA medical facilities, sharing the costs of faculty and residents when residents are training in VA facilities. When a resident is training at a VA facility, that resident is not counted as part of the Medicare GME cap for the sponsoring institution (and so is not paid via Medicare). This allows the sponsoring institution to train additional residents above its Medicare cap. Over 43,000 residents and fellows rotate through roughly 11,000 VA-funded full-time-equivalent residency positions in VA medical facilities each year; while rotating through the VA, residents remain employees of the sponsoring institution and are not employees of the VA, nor are they subject to service obligations upon completion of the rotation or training program.[1] Approximately one third of the entire GME workforce per year receives training in VA facilities and provides care to veterans.[2]

VA GME Expansion

The Veterans Access, Choice, and Accountability Act (VACAA) of 2014 included a requirement that the VA expand the number of residents and fellows it trains by up to 1,500 positions by 2024, in selected specialties and/or geographic areas, as well as specialties designated as critical need specialties located within health professional shortage areas (as defined by the Health Resources and Services Administration), having a shortage of physicians, rural locations, or in a program/area where there are significant delays in veteran access to care.[3] After five rounds, the VA has approved 1,055 positions, from 2015 through 2019 (443.2 in primary care, 229.1 in mental health, and 383.0 in critical need specialties).[4]

Subsequent legislation introduced in 2017, but not passed, also increased the number of GME positions funded by the VA by 1,500, but required a service obligation post-GME equal to the number of years of residency stipend and benefit support.[5,6]

The VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 builds upon VACAA in that one of its aims is to increase GME in rural locations, an area in which VACAA has had limited success.[4] The MISSION Act will enable the VA to place at least 100 residents (through positions created by VACAA) in "covered" federal facilities, that may not be on a traditional VA campus. Indian Health Service facilities, Federally Qualified Health Centers, Department of Defense medical centers, or other underserved VA areas are included as sites for potential GME expansion. The MISSION Act also provides the VA authority to assist in the development costs of starting new GME programs in VA-designated underserved areas. Finally, the MISSION Act includes provisions to enable the VA to recruit physicians and dentists into rural and underserved areas through two scholarship opportunities and a loan repayment program. The Health Professions Scholarship Program (HPSP) will offer scholarships to medical and dental students in exchange for VA service, with a repayment period of 18 months per year of support. Upon completion of training, the participants will be assigned by the VA to areas experiencing a critical need in the specialty of training. The number of scholarships to be funded will be based on VA-determined provider shortages.[7]

A second scholarship opportunity provides four years of tuition, fees and stipend support to two veterans at nine medical schools:

- Charles R. Drew University of Medicine and Science (California)
- Howard University College of Medicine (District of Columbia)

- Morehouse School of Medicine (Georgia)
- Wright State University Boonshoft School of Medicine (Ohio)
- University of South Carolina School of Medicine
- East Tennessee State University James H. Quillen College of Medicine
- Meharry Medical College (Tennessee)
- Texas A&M Health Science Center College of Medicine
- Joan C. Edwards School of Medicine at Marshall University (West Virginia)

After completion of residency or fellowship, the recipient of the scholarship is required to practice in a VA facility for four years.[7]

The Specialty Education Loan Repayment program offers $40,000 in loan repayment to residents (who have at least two or more years left of training) in exchange for 12 months' service post-GME in a VA medical center or site, with a maximum of $160,000 loan repayment. Preferences will be given to veterans, residents training in rural areas or in the Indian Health Services, or in sites in underserved areas. Rather than an assignment by the VA, recipients in the loan repayment program can select from a list of approved sites the location of the VA site for their service obligation.[7]

To date, the Specialty Education Loan Repayment program has been enacted. The scholarship opportunity for recently separated military veterans attending selected medical schools will be offered to the medical school class of 2020, as a trial, with hope of its continuation. The language for the HPSP scholarship opportunity is currently in development and not yet published for public comment. It is anticipated that the GME expansion in "covered" facilities, as well as the creation of new GME programs in Indian Health Service (IHS) and tribal facilities, will not be underway until at least 2022.[8]

RELEVANT AMA POLICY

D-510.990, "Fixing the VA Physician Shortage with Physicians"

Our AMA will: (1) work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities; (2) Call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility; (3) Work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans; (4) (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.

SUMMARY AND RECOMMENDATIONS

The health care system of the VA is the largest system in the U.S. Not only does the VA provide training opportunities for over 43,000 residents and fellows, it also has collaborative agreements with 178 allopathic and osteopathic medical schools, providing educational opportunities for nearly 25,000 medical students and other health professions trainees[7] (who are not subject to service obligations upon completion of the rotation or training program). As such, the importance and value of the VA to the nation's health care workforce cannot be overstated.

While other sources of financing for more GME positions have been limited, the VA's ability to expand may reduce the effects of a forecasted physician shortage. Recently passed legislation that enables the VA to expand opportunities for physician training within the VA, and to provide financial assistance to eligible physicians who will then repay that assistance through service obligation to VA and other underserved populations, will further one of the statutory missions of the VA, which is to assist in the training of health professionals for its own needs and those of the nation.

The Council on Medical Education therefore recommends that the following recommendations be adopted in lieu of Resolution 954-I-18 and the remainder of this report be filed:

1. That our AMA support postgraduate medical education service obligations through any program where the expectation for service is explicitly delineated in the contract with the trainee. (New HOD Policy)

2. That our American Medical Association (AMA) oppose the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training. (New HOD Policy)

Fiscal note: $500.

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REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-19)
Mechanisms to Address High and Escalating Pharmaceutical Prices
(Reference Committee J)

EXECUTIVE SUMMARY

At the past several meetings of the House of Delegates, significant concerns have been raised regarding how high and increasing drug prices have impacted patients and physician practices. The Council on Medical Service spent the past year reviewing the substantial body of American Medical Association (AMA) policy pertaining to pharmaceutical costs and pricing, and concluded that additional policy is needed to respond to innovative proposals addressing pharmaceutical pricing that could potentially be included in future legislation and regulations, including those that call for the use of arbitration, leverage international price indices and averages to determine drug prices, or implement contingent exclusivity periods for pharmaceuticals.

The Council has long prioritized the importance of competition and transparency in the pharmaceutical marketplace, but recognizes that there are multiple situations in which payers have weakened bargaining power, due to lack of competition for some drugs. In addition, there is often limited recourse following an unjustifiable price hike of a prescription medication, leaving patients questioning whether they will be able to continue to afford their medication. As such, the Council recommends policies to promote reasonable pricing behavior in the pharmaceutical marketplace, as an alternative to price controls.

First, the Council recommends principles to guide the use of arbitration in determining the price of prescription drugs, which build upon existing policy in favor of drug price negotiation, and opposed to price controls. Arbitration should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases. Using arbitration will help rebalance the importance of prescription drug affordability with the need for innovation, as an alternative to the status quo, which allows unilateral price setting of drugs by manufacturers without regard to patient access and affordability. Importantly, arbitration provides an incentive for drug manufacturers and payers to arrive at a negotiated price.

The Council stresses that arbitration should be coupled with additional policy proposals that promote value and encourage competition within the pharmaceutical marketplace. The Council believes that incorporating a drug's value and cost-effectiveness as factors in determining its length of market exclusivity has the potential to promote increased competition for therapies that are priced too high in relation to their clinical effectiveness and overall value. As such, the Council recommends support for the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of a drug to its cost-effectiveness at its list price at the time of market introduction.

Finally, with the introduction of proposals that would use the average of a drug's price internationally to serve as an upper limit in drug price negotiations, set a drug's price in Medicare Part B or determine whether a drug's price is "excessive" to trigger additional interventions, the Council recommends safeguards to ensure that such international drug price averages are used in a way that upholds market-based principles and preserves patient access to necessary medications.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-I-19

Subject: Mechanisms to Address High and Escalating Pharmaceutical Prices

Presented by: W. Alan Harmon, MD, Chair

Referred to: Reference Committee J

At the past several meetings of the House of Delegates, significant concerns have been raised regarding how high and increasing drug prices have impacted patients and physician practices. The Council on Medical Service spent the past year reviewing the substantial body of American Medical Association (AMA) policy pertaining to pharmaceutical costs and pricing, determining whether additional policy was needed to guide future AMA advocacy efforts. In its review, the Council concluded that additional AMA policy is needed to respond to innovative proposals addressing pharmaceutical pricing that could potentially be included in future legislation and regulations, including those that call for the use of arbitration, leverage international price indices and averages to determine drug prices, or implement contingent exclusivity periods for pharmaceuticals.

This report provides background on the impacts of high and escalating prescription drug prices and costs; outlines emerging approaches to address pharmaceutical pricing; and presents policy recommendations.

THE IMPACTS OF HIGH AND ESCALATING PRESCRIPTION DRUG PRICES AND COSTS

Retail prescription drugs account for 10 percent of total health spending,[1] with estimates suggesting that spending on prescription drugs is closer to 15 percent of total health spending when other factors, including the non-retail drug markets and gross profits of other stakeholders involved in drug distribution, payment, and reimbursement are included.[2] Of significance, spending on specialty drugs is approaching one-half of drug spending.[3] The most recent National Health Expenditure projections showed that retail prescription drug spending was estimated to have increased by 3.3 percent to $344.5 billion in 2018, with a 4.6 percent increase in spending expected in 2019. Drivers behind the rate of growth in prescription drug spending include a higher number of new drug introductions, increased utilization of prescription drugs, and an increase in drug price growth. The projected annual growth in prescription drug spending is expected to average 6.1 percent from 2020 through 2027. Contributions to future growth in spending in the prescription drug sector include increased prescription drug utilization resulting from employer and insurer efforts to remove barriers associated with medications for chronic conditions; expected market release of more expensive drugs for conditions including cancer, diabetes, and Alzheimer's disease; the aging of the population; and modifications to pharmacotherapy guidelines.[4]

Approximately 5.8 billion prescriptions were dispensed in the US in 2018, 90 percent of which were dispensed as generics. The retail price differentials between specialty, brand-name and generic drugs are noteworthy. Examining the retail prices of drugs widely used by older Americans, in 2017 the average annual retail price of therapy for specialty drugs was $78,781, dropping to $6,798 for brand-name drugs, and $365 for generics.[5] Overall, the list price of the

average brand drug was $657.08 for a 30-day prescription in 2018, a noteworthy increase from $364.92 in 2014. The average prices of brand-name drugs at pharmacies before coupons and discounts are applied were $229 lower than list prices in 2018 for a 30-day prescription.[6] Average generic pharmacy prices for a 30-day prescription were relatively stable from 2014 to 2018, increasing to $19.10 from $18.50.[7]

Health plans, payers, employers, physicians and patients are facing the increasing financial burden posed by prescription drugs, both brand and generic. In the Medicare program, between 2007 and 2017, Part D program spending has seen an annual growth rate of 5.6 percent, and amounted to $79.9 billion in 2017. Premiums paid by Part D enrollees for basic benefits (not including low-income subsidy enrollees) amounted to $14 billion in 2017, which has increased by 13 percent on average annually since 2007. High-cost enrollees are a primary contributor to Part D spending growth, with the associated spending growth for high-cost enrollees resulting from higher drug prices.[8] Under Medicare Part B, drug spending has increased on average by 9.6 percent annually between 2009 and 2017, with the largest driver of this growth in spending being price growth – a combination of increasing prices for existing drugs as well as the introduction of new high-cost drugs in the market. In 2017, $18 billion of total Part B spending was for drugs administered in physician offices, approximately $12.3 billion was for drugs administered in hospital outpatient departments, and $1.8 billion was for drugs provided by suppliers.[9]

Rising and high prescription drug prices are impacting Medicaid budgets and state budgets overall. Under the Medicaid drug benefit, drug manufacturers pay rebates to states in return for Medicaid reimbursement for their prescription drugs. Drug manufacturers are required to pay an additional rebate amount if the average manufacturer price (AMP) for a drug rises faster than inflation. From 2014 to 2017, Medicaid outpatient prescription drug spending before rebates increased from $45.9 billion to $63.6 billion.[10] The $34.9 billion collected in rebates brought net Medicaid spending on prescription drugs down significantly in fiscal year (FY) 2017. The proportion of spending geared to brand-name versus generic drugs in Medicaid increased – from 76.6 percent in FY 2014 to 80.5 percent in FY 2017. This growth resulted from an increase in average spending per claim for brand drugs – from $294 per claim in FY 2014 to $411 per claim in FY 2017. Of note, the share of spending on specialty drugs has significantly increased in Medicaid – accounting for approximately 44 percent of spending in FY 2017.[11]

Employer-sponsored health plans as well as health plans sold in the individual market have also had to absorb the higher costs of prescription drugs, which often translate to higher premiums, higher prescription drug cost-sharing, and additional prescription drug tiers to accommodate the higher costs of specialty and certain generic drugs. In 2018, 88 percent of employees were enrolled in plans with three, four or more cost-sharing tiers for prescription drugs.[12] This year, almost all standalone Medicare Part D plans have a benefit design with five tiers for generic and brand-name drugs and cost-sharing that deviates from the standard 25 percent coinsurance for all covered drugs between the deductible and the initial coverage limit.[13]

The higher costs of prescription drugs are in part passed down to health plan enrollees, and impact physician practices. Ultimately, prescription drug costs can impact the ability of physicians to place their patients on the best treatment regimen, due to the regimen being unaffordable for the patient, or being subject to coverage limitations and restrictions, as well as utilization management requirements, by the patient's health plan. In the worst-case scenario, patients entirely forgo necessary treatments involving drugs and biologics due to their high cost.

In 2018, overall out-of-pocket costs for prescription drugs reached $61 billion, an increase from $56 billion in 2014. Across Medicare, Medicaid and commercial health plans, 8.8 percent of

patients pay more than $500 per year out-of-pocket for prescriptions. Medicare beneficiaries have a notably higher incidence rate of high out-of-pocket expenses for prescription drugs, with almost 20 percent paying more than $500 out-of-pocket.[14] Nonpreferred generic tiers in many cases have higher copayments than patients have become accustomed to for generic medications. In addition, plans with specialty drug cost-sharing tiers often require coinsurance amounts of 25 to 50 percent, versus requiring a fixed copayment. Considering the costs of many specialty medications, patients could quickly reach their deductibles and out-of-pocket maximums. The increased use and cost of specialty drugs in Medicare could cause the number of Part D enrollees who reach the catastrophic coverage threshold to grow substantially, resulting in increases in Medicare spending to plans for reinsurance.

Increasing patient cost-sharing is associated with declines in medication adherence, which in turn can lead to poorer health outcomes. Among those currently taking prescription drugs, approximately a quarter of adults and seniors have reported difficulties in affording their prescription drugs. Approximately 30 percent of all adults have reported not taking their medications as prescribed at some point in the past year due to cost. Drilling down further, 19 percent of adults have not filled a prescription in the past year due to cost, 18 percent chose to take an over-the-counter medication instead, and 12 percent cut pills in half or skipped doses. Of significance, almost 10 percent of all adults reported that their condition worsened from not taking their medication as prescribed.[15]

Notably, out-of-pocket costs for prescription drugs are linked to the rate at which patients newly prescribed a drug either do not pick up their prescription or switch to another product. The rate at which such patients, enrolled in either Medicare or a commercial health plan, abandon their prescription increases significantly once out-of-pocket costs reach $50. At this point, 31.2 percent of commercially insured patients and 27.6 percent of Medicare patients abandon their prescriptions.[16]

High prescription drug costs, and any declines in medication adherence that may result, can also impact physicians participating in alternative payment models (APMs). For example, Part B drug costs are included in calculations of APM financial risk, even though physicians cannot influence or control drug prices. In addition, physicians in APMs can be affected if poor medication adherence leads to complications or exacerbations that in turn lead to emergency department visits and/or hospital admissions.

EMERGING APPROACHES TO ADDRESS HIGH AND ESCALATING DRUG PRICES

Escalating and increasingly unaffordable drug prices have caused the Administration, members of Congress and policy experts to put forward innovative proposals to put downward pressure on prices, or more closely tie a drug's price to its value. Whereas proposals that would allow for binding arbitration and contingent exclusivity periods could build upon existing market-based approaches to address pharmaceutical prices and costs, caution would have to be exercised in implementing proposals that leverage international price indices, so as to not merely import international price controls into the US.

Utilizing Binding Arbitration

An emerging policy option that has been put forward to address high and escalating drug prices is using binding arbitration in the event of failed drug price negotiations in order to settle on the final price of the drug. Supporters argue that binding arbitration has the potential to build upon the negotiations that currently take place along the pharmaceutical supply chain that determine

coverage of and payment for prescription drugs. In the US, binding arbitration is currently used in public-sector labor-management negotiations, and Major League Baseball uses the approach in the event of failed negotiations for baseball players' salaries. While negotiated prices between the pharmaceutical company and the payer/government entity in question would remain the preferred solution, arbitration has the potential to help equalize the bargaining power of both parties of the negotiation, while incentivizing negotiating parties to negotiate in good faith. If negotiations fail to conclude with a price agreeable to both parties, they could submit to final offer arbitration or conventional arbitration.

In final offer arbitration, the arbitrator would be given final bids by the drug manufacturer and the payer/government entity in question. Such bids would be accompanied by data justifying the price put forward by each party, and there would be potential for an independent third party to offer a third price, which can be informed by value-based price benchmarks, comparative effectiveness research, and cost-effectiveness analysis. The arbitrator under final offer arbitration would be required to choose one of three prices: 1) the bid of the drug manufacturer; 2) the bid of the payer/government entity; or 3) the price submitted by the independent third party, if applicable. Alternatively, under conventional arbitration, the arbitrator would not be tied to any of the bids or options put forward; they could select any price they believe is fair.[17]

Case Study: Germany

Germany uses arbitration as one potential pathway to determine the price of a drug in the German market. After a drug is approved by the European Medicines Agency, allowing for the drug to be sold in Germany, a drug manufacturer unilaterally sets the drug's price, applicable for 12 months. At the same time, the manufacturer also is required to submit a report outlining the benefits of the drug to the Federal Joint Committee, comprised of physicians, dentists, hospitals, and health insurers (sickness funds). The Federal Joint Committee forwards the report to the non-governmental Institute for Quality and Efficiency in Health Care (IQWiG), which conducts an assessment of the clinical effectiveness and benefits of the new drug compared with one or more comparator therapies. After the IQWiG submits its finding, the Federal Joint Committee issues a final decision regarding the level of benefit of the new drug relative to existing therapies that treat the condition in question. Such benefits can include prolonged life expectancy, reduction in side effects, health status improvement, shortening of disease duration and quality of life improvement. A drug is then assigned one of six benefit ratings:

1. Major added benefit
2. Considerable added benefit
3. Minor added benefit
4. Nonquantifiable added benefit
5. No evidence of added benefit
6. Lower benefit than comparator(s)

Depending on a drug's benefit rating, and whether there is a reference group to guide a reference price of a drug, a drug manufacturer can either enter into negotiations with Germany's sickness funds (health insurers), or be assigned to a therapeutic class subject to reference pricing – pricing based on other drugs in the same therapeutic class, including generics. Drugs that enter into negotiations have six months from the Federal Joint Committee decision to agree to a price. If they cannot agree on a price, an arbitration panel is required to set a price within three months, which is binding for the following year. Either party can challenge the decision, which would then trigger IQWiG conducting a cost-benefit analysis. In addition, new findings can serve as cause for the parties to revisit an agreement or arbitration decision after one year.[18,19,20]

Relevant AMA Policy

Policy D-330.954 supports federal legislation which gives the Secretary of Health and Human Services (HHS) the authority to negotiate contracts with manufacturers of covered Part D drugs; and states that the AMA will work toward eliminating Medicare prohibition on drug price negotiation and prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS. Policy II-155.962 states that our AMA opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services.

Policy H-110.986 supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion. Policy H-110.986 also supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. Policy H-460.909 outlines principles for creating a centralized comparative effectiveness research entity.

Leveraging an International Pricing Index

Recent proposals put forward by the Administration and members of Congress attempt to lower US drug costs by tying them to international prices, and/or would use an average of international prices, or an international reference price, to help define whether a price of a drug is excessive. In October of 2018, the Administration released an Advance Notice of Proposed Rulemaking (ANPRM) for a proposal entitled "International Pricing Index Model for Part B Drugs." The ANPRM did not represent a formal proposal, but outlined the Administration's current thinking and sought stakeholder input on a variety of topics and questions related to this new drug pricing model prior to entering formal rulemaking. At the time that this report was written, a proposed rule on the international pricing index model was expected to be released, which has the potential to differ markedly from what was outlined in the ANPRM.

The ANPRM outlined a new payment model for physician-administered drugs paid under Medicare Part B that will transition Medicare payment rates for certain Part B drugs to lower rates that are tied to international reference prices – referred to as the "international pricing index" – except where the average sales price (ASP) is lower. The international reference price would partly be based on an average of prices paid by other countries. To accomplish this, the proposal would create a mandatory demonstration through the Centers for Medicare & Medicaid Innovation (CMMI), which would apply to certain randomly selected geographic areas, representing approximately 50 percent of Medicare Part B drug spending. Initially, the program would apply only to sole-source drug products and some biologics for which there is robust international pricing data available.

In geographic areas included in the demonstration, CMS would contract with private-sector vendors that will negotiate for, purchase, and supply providers with drug products that are included in the demonstration. CMS would directly reimburse the vendor for the included drugs, starting with an amount that is more heavily weighted toward the ASP instead of the international pricing index, and transitioning toward a target price that is heavily based on the international pricing index. Providers would select vendors from which to receive included drugs, but would not be responsible for buying from and billing Medicare for the drug product.

An alternative international drug price index has been put forward, which differs from that introduced in the ANPRM: the Market-Based International Index (MBII). Unlike the international price index included in the ANPRM, the MBII excludes developed countries with single-payer health systems that use price controls. Therefore, unlike the index provided for the ANPRM, the MBII does not include Canada, Finland, Greece, Italy, Spain, Sweden and the United Kingdom. The MBII benchmark has two tiers. The first tier represents 60 percent of the benchmark, and includes the Netherlands, Singapore and Switzerland – countries with truly market-based health systems – as well as Denmark, which does not regulate drug prices. The second tier, which constitutes 40 percent of the benchmark, includes Austria, Belgium, the Czech Republic, France, Germany, Ireland, Japan, Portugal, and Slovakia – countries that have a mix of private and public health insurance.[21]

Legislation has also been introduced in Congress that would use international drug prices to determine whether a drug's price is excessive, trigger additional interventions, and serve as an upper limit in drug price negotiations. Senator Bernie Sanders (I-VT) and Representative Ro Khanna (D-CA) have introduced S 102/HR 465, the Prescription Drug Price Relief Act of 2019. Notably, under the bill, the price of a prescription drug would be considered "excessive" if the domestic average manufacturing price exceeds the median price for the drug in Canada, the United Kingdom, Germany, France, and Japan. Even if a drug's price does not meet this criterion, or if pricing information is unavailable in at least three of the five countries, a drug's price could still be considered excessive if it is higher than reasonable in light of factors outlined in the legislation, including cost, revenue, and the size of the affected patient population. If brand-name drugs are found to be excessively priced, the drug would be included on a public excessive price database. Open, nonexclusive licenses would be issued for the drug; and review of corresponding applications for generic drugs and biosimilar biological products would be expedited to facilitate competition as well as the entry of lower-cost options into the marketplace.[22,23]

In addition, Congressman Frank Pallone (D-NJ) has introduced HR 3, the Lower Drug Costs Now Act of 2019. The legislation would incorporate an international price average as part of authorizing the Secretary of HHS to negotiate drug prices, limited to drugs that lack competition and have the greatest financial impact to the Medicare program and the US health system as a whole, as well as insulin. The Secretary of HHS would directly negotiate with drug manufacturers to establish a maximum fair price for drugs selected for negotiation, which would be applied to Medicare, with flexibility for Medicare Advantage and Medicare Part D plans to use additional tools to negotiate even lower prices. In addition, the drug manufacturer would be required to offer the negotiated price to private group and individual health insurance plans. An "average international market price" would be established to serve as an upper limit for the price reached in any negotiation, if practicable for the drug at hand, defined as no more than 120 percent of the drug's volume-weighted net average price in six countries – Australia, Canada, France, Germany, Japan and the United Kingdom. There would be a financial penalty if a pharmaceutical manufacturer does not participate in or comply with the negotiations.

Relevant AMA Policy and Advocacy

Pursuant to AMA Policy, the AMA submitted comments in response to the "International Pricing Index Model for Part B Drugs" in December 2018. Policy H-155.962 opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services. Policy H-110.983 advocates that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:

- it must be genuinely voluntary and not penalize practices that choose not to participate;
- it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;
- it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate health care inflation rate;
- it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of (CAP)-acquired drugs at multiple office locations;
- it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
- it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
- it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
- it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

Tying Pharmaceutical Pricing to Market Exclusivity

Brand-name drugs have 20 years of patent protection from the date of filing, and also enjoy a period of market exclusivity, depending on the type of drug. Orphan drugs – drugs to treat rare diseases or conditions affecting less than 200,000 individuals in the US, or affecting more than 200,000 individuals but for which there is not a reasonable expectation that the sales of the drug would recover the costs – have seven years of market exclusivity. Drugs deemed to be innovative products that include an entirely new active ingredient – a new chemical – have five years of market exclusivity. Six months of exclusivity are added to existing exclusivity periods once studies on the effects of a drug upon children are submitted for Food & Drug Administration (FDA) review and meet the statutory requirements. Biologic manufacturers have 12 years of exclusivity for innovator (brand-name) products. Innovator biologics also have additional patent protection that generally exceeds exclusivity period by a few years.[24]

Exclusivity periods for pharmaceuticals are not tied to the list price at which they enter the market, nor to the rate at which they increase in price from year to year. The Council notes that two potential options have been proposed to more closely tie drug market exclusivity to pricing behavior. First, a policy strategy has been put forward to implement contingent exclusivity periods for new brand drugs. Under this policy option, drug manufacturers with a newly approved drug would be able to set their list price at whatever they wish, but the length of the exclusivity period would depend on whether their list price is reasonable, ie, if it aligns with the drug's value. Multiple options could be utilized to assess a drug's value, including cost per quality-adjusted life

year (QALY), or a value-based price benchmark. Contingent exclusivity periods, therefore, could potentially lengthen the exclusivity period for drugs with lower cost per QALY, and reduce the exclusivity period for drugs priced too highly to align with their value. For example, in the case of an innovator biologic, a biologic with a low cost per QALY could see its exclusivity period extended to 15 years from 12 years, whereas a biologic priced too high relative to its value could have its exclusivity period set to 7 years.[25]

Second, Senator Richard Durbin (D-IL) and Representative Jared Golden (D-ME) introduced S 366/HR 1188, the Forcing Limits on Abusive and Tumultuous (FLAT) Prices Act, which would shorten (but not automatically void) the Food, Drug, and Cosmetic Act market exclusivity period for prescription drugs that experience sudden increases in price. Under the FLAT Prices Act, an increase of the wholesale acquisition cost of a prescription drug of more than 10 percent over a one-year period, more than 18 percent over a 2-year period, or more than 25 percent over a three-year period would result in a reduction of market exclusivity of 180 days. For every five percent increase over these thresholds, the market exclusivity would be reduced an additional 30 days. Manufacturers would be required to report such price increase within 30 days of meeting the criteria for a price increase. Failure to report within the allotted time would result in 30 days of reduced exclusivity daily until the report is submitted. The Secretary of HHS would have discretion to grant a waiver to a manufacturer if the Secretary determines that the price increase is justified and does not unduly restrict patient access to the drug or impact public health.[26,27]

Relevant AMA Policy

Policy H-110.987 supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations. The policy also supports drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase; legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10 percent or more each year or per course of treatment. In addition, it advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase. Finally, it states that our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

Policy H-110.986 supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help

assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.

Policy H-110.986 also supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. Finally, it supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including Hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

DISCUSSION

Physicians experience and see first-hand the difficulty and burden high pharmaceutical costs have imposed on patients, on physician practices, and the broader health care system. Patients delay, forgo, or ration their medication when treatments are cost-prohibitive, putting their health at risk. At a time of significantly increasing drug prices, and the launch of products with high list prices, the Council believes that more needs to be done to improve access to and lower the costs of prescription drugs, without stifling innovation.

The Council has long prioritized the importance of competition and transparency in the pharmaceutical marketplace, and believes that negotiation of drug prices between drug manufacturers and payers should continue to be the preferred mechanism to determine how drugs are covered and paid for. That being said, the Council recognizes that there are multiple situations in which payers have weakened bargaining power, due to a drug's lack of competition in the marketplace. In addition, there is often limited recourse following an unjustifiable price hike of a prescription medication, leaving patients questioning whether they will be able continue to afford their medication. As such, the Council recommends policies to promote reasonable pricing behavior in the pharmaceutical marketplace, as an alternative to price controls.

First, the Council recommends principles to guide the use of arbitration in determining the price of prescription drugs, which build upon existing policy in favor of drug price negotiation, and opposed to price controls. Of note, arbitration can serve a role in many circumstances, from negotiating drug prices in Medicare Part D, to any negotiations that take place following a drug product's market entry, as executed in Germany. The Council believes that arbitration should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases. Using arbitration will help rebalance the importance of prescription drug affordability with the need for innovation, as an alternative to the status quo, which allows unilateral price setting of drugs by manufacturers without regard to patient access and affordability. Importantly, arbitration provides an incentive for drug manufacturers and payers/government entities to arrive at a negotiated price.

To ensure that there is a pathway to use arbitration in Medicare Part D, the Council recommends the reaffirmation of Policy D-330.954, which supports removing the current prohibition that restricts the Secretary of HHS from being able to negotiate drug prices in Part D. In whatever setting arbitration for drug prices is used, the Council underscores that the process should be overseen by objective, independent entities, which would have the authority to select neutral arbitrators or an arbitration panel, with strong conflict-of-interest protections built in.

The Council believes that as part of the arbitration process, and to guide the results, the use of comparative effectiveness research and cost-effectiveness analysis will be critical. Related, the arbitration process should include the submission of a value-based price benchmark for the drug in question to inform the arbitrator's decision, pursuant to Policy H-110.986.

The Council stresses that arbitration should be coupled with additional policy proposals that promote value and encourage competition within the pharmaceutical marketplace. The Council believes that incorporating a drug's value and cost-effectiveness as factors in determining its length of market exclusivity has the potential to promote increased competition for therapies that are priced too high in relation to their clinical effectiveness and overall value. As such, the Council recommends support for the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of a drug product to its cost-effectiveness at its list price at the time of market introduction.

Finally, with the introduction of proposals that would use the average of a drug's price internationally to serve as an upper limit in drug price negotiations, set a drug's price in Medicare Part B or determine whether a drug's price is "excessive" to trigger additional interventions, the Council recommends safeguards to ensure that such international drug price averages are used in a way that uphold market-based principles and preserve patient access to necessary medications. In addition, the Council recommends reaffirmation of Policy H-110.983 outlining standards for any revised Medicare Part B Competitive Acquisition Program, which is relevant considering recent proposals to incorporate an international pricing index in Medicare Part B.

The Council believes that the recommendations of this report add to the already large body of AMA policies that address the high cost of prescription medications, which guide AMA advocacy efforts to improve patient access to medication while reducing their costs and balancing the need for appropriate innovation incentives. Pursuant to these policies, the AMA supports: (1) requiring manufacturer and pharmaceutical supply chain transparency; (2) increasing competition and curtailing anti-competitive practices; (3) ensuring prescribers have accurate point-of-care coverage and patient cost-sharing information as part of their workflow including in the electronic health record; and (4) streamlining and modernizing the utilization control methods used by health insurers in response to higher prescription drug costs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:

    a. The arbitration process should be overseen by objective, independent entities;
    b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
    c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
    d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
    e. The arbitration process should include the submission of a value-based price benchmark for the drug in question to inform the arbitrator's decision;
    f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer/government entity;
    g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases; and

h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision. (New HOD Policy)

2. That our AMA advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

   a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
   b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
   c. The use of any international drug price index or average should preserve patient access to necessary medications; and
   d. The use of any international drug price index or average should limit burdens on physician practices. (New HOD Policy)

3. That our AMA support the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (New HOD Policy)

4. That our AMA reaffirm Policy H-110.983, which advocates that any revised Medicare Part B Competitive Acquisition Program meet certain outlined standards to improve the value of the program by lowering the cost of drugs without undermining quality of care. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-110.986, which outlines principles for value-based pricing programs, initiatives and mechanisms for pharmaceuticals, and supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-460.909, which outlines principles for creating a centralized comparative effectiveness research entity. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-330.954, which states that our AMA will work toward eliminating Medicare prohibition on drug price negotiation. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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Note: this table includes only the recommendations from reports and the resolve statements from resolutions. The table can be sorted in Word using either the "committee" column or the "item" column (or both). Alternatively, the table can be copied to a spreadsheet and manipulated there. The table includes all items of business contained in the initial Handbook excepting informational reports. Only the primary sponsor, usually the submitter, is listed for resolutions

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
.Con	CCB 01	n/a	Parity in our AMA House of Delegates The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting. 2.10 Registration and Seating of Delegates. *** **2.10.5 Constituent Association President.** The current president of a constituent association may also be certified as an additional alternate delegate at the discretion of each constituent association. **2.10.6 National Medical Specialty Society or Professional Interest Medical Association President.** The current president of a national medical specialty society or a professional interest medical association may also be certified as an additional alternate delegate at the discretion of each national medical specialty society or professional interest medical association.
.Con	CCB 02	n/a	Bylaw Consistency--Certification Authority for Societies represented in our AMA House of Delegates and Advance Certification for those Societies The Council on Constitution and Bylaws recommends: 1) that the following amendments to the AMA Bylaws be adopted; and 2) that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting. **2.1.4 Certification.** The president ~~or secretary~~ of each constituent association, or the president's designee, shall certify to the AMA the delegates and alternate delegates from their respective associations. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates. ***

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			2.2.4 Certification. The president ~~or secretary~~ of each specialty society, or the president's designee, shall certify to the AMA the delegates and alternate delegates from their respective societies. Certification must occur at least 30 days prior to the Annual or Interim Meeting of the House of Delegates. *** **2.3.4 Certification.** The Chair of the Medical Student Section Governing Council, or the Chair's designee, shall certify to the AMA the delegates and alternate delegates ~~for~~ from each Medical Student Region. Certification of delegates and alternate delegates must occur at least 30 days prior to the Annual Meeting of the House of Delegates. *** **2.4.4 Certification.** The Chair of the Resident and Fellow Section Governing Council, or ~~his or her~~ the Chair's designee, shall certify to the AMA the delegates and alternate delegates for the Resident and Fellow Section. Certification of delegates and alternate delegates must occur at least 30 days prior to the Annual Meeting of the House of Delegates. *** **2.6 Other Delegates.** Each of the following is entitled to a delegate: AMA Sections; the Surgeons General of the United States Army, United States Navy, United States Air Force, and United States Public Health Service; the Chief Medical Director of the Department of Veterans Affairs; the National Medical Association; the American Medical Women's Association; the American Osteopathic Association; and professional interest medical associations granted representation in the House of Delegates. **2.6.1 Certification.** The president~~, secretary~~ or other authorized individual of each entity shall certify to the AMA their respective delegate and alternate delegate. Certification must occur 30 days prior to the Annual or Interim Meeting. **2.10 Registration and Seating of Delegates.** *** **2.10.2 Credentials.** A delegate or alternate delegate may only be seated if there is ~~Before being seated at any meeting of the House of Delegates, each delegate or alternate delegate shall deposit with the Committee on Rules and Credentials a certificate~~ certification on file ~~signed by the president, secretary, or other authorized individual of~~

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			~~the delegate's or alternate delegate's organization~~ stating that the delegate or alternate delegate has been properly selected to serve in the House of Delegates. **2.10.3 Lack of Credentials.** A delegate or alternate delegate may be seated without the certificate defined in Bylaw 2.10.2 provided proper identification as the delegate or alternate delegate selected by the respective ~~organization~~ entity is established, and so certified to the AMA. **2.10.4 Substitute.** When a delegate or alternate delegate is unable to attend a meeting of the House of Delegates, the ~~appropriate authorities~~ president, the president's designee or other authorized individual of the ~~organization~~ entity may appoint a substitute delegate or substitute alternate delegate, who ~~on presenting proper credentials~~ shall be eligible to serve as such delegate or alternate delegate in the House of Delegates at that meeting. **2.10.4.1 Temporary Substitute Delegate.** A delegate whose credentials have been accepted by the Committee on Rules and Credentials and whose name has been placed on the roll of the House of Delegates shall remain a delegate until final adjournment of that meeting of the House of Delegates. However, if the delegate is not able to remain in attendance, that place of that delegate may be taken during the period of absence by an alternate delegate, or a substitute alternate delegate selected in accordance with Bylaw 2.10.4 if an alternate delegate is not available. The person who takes the place of the delegate must ~~comply with the formal recredentialing procedures established by the Committee on Rules and Credentials for such purpose~~ have certification on file and shall be known as a temporary substitute delegate. Such temporary substitute delegate shall have all of the rights and privileges of a delegate while serving as a temporary substitute delegate, including the right to vote in the House of Delegates and to vote in any election conducted by the House of Delegates. The temporary substitute delegate shall not be eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. *** **2.10.~~6~~7 Representation.** No delegate or alternate delegate may be ~~registered~~ credentialed or seated at any meeting to represent more than one organization in the House of Delegates.
.Con	CCB 03	n/a	AMA Delegation Apportionment The Council on Constitution and Bylaws recommends the following: 1. That the following amendment to the AMA Bylaws be adopted. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting. **2.1 Constituent Associations.** Each recognized constituent association granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and

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			such additional delegate seats as may be provided under Bylaw 2.1.1.2. Only one constituent association from each U.S. state, commonwealth, territory, or possession shall be granted representation in the House of Delegates. **2.1.1 Apportionment.** The apportionment of delegates from each constituent association is one delegate for each 1,000, or fraction thereof, active constituent and active direct members of the AMA within the jurisdiction of each constituent association, as recorded by the AMA as of December 31 of each year. 2.1.1.1 The December 31 count will include pending members for purposes of apportionment; however, pending members shall not be recounted the following year absent membership renewal. This Bylaw will sunset as of the close of business of the 2022 Interim Meeting unless the House of Delegates acts to retain it. [Subsequent bylaw provisions shall be renumbered] (Modify Bylaws) 2. That Policy G-600.016(2) be amended by addition to read as follows: "Pending members" (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity. (Modify Current HOD Policy) 3. That the remainder of this report be filed.
.Con	CEJA 01	n/a	Competence, Self-Assessment and Self-Awareness Based on the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed: The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians' technical knowledge and skills. However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when

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			they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to: (a) Cultivate continuous self-awareness and self-observation. (b) Recognize that different points of transition in professional life can make different demands on competence. (c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations. (d) Seek feedback from peers and others. (e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest. (f) Maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness. (g) Intervene in a timely, appropriate, and compassionate manner when a colleague's ability to practice safely is compromised by impairment, in keeping with ethics guidance on physician responsibilities to impaired colleagues. Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.
.CON	CEJA 02	n/a	Amendment to E-1.2.2, "Disruptive Behavior by Patients" In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, "Discrimination against Physicians by Patients," be rescinded; Opinion 1.2.2, "Disruptive Behavior by Patients," be amended by addition and deletion as follows; and the remainder of this report be filed: The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting ~~their~~ the dignity and rights of both patients and physicians. Disrespectful, ~~or~~ derogatory, or prejudiced, language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either physicians or patients can undermine trust and compromise the integrity

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			of the patient-physician relationship. It can make members of targeted groups reluctant to seek or provide care, and create an environment that strains relationships among patients, physicians, and the health care team. Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should: (a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those ~~they target~~ who are targeted. (b) Always treat patients with compassion and respect. (c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient's behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat. (d) In general, decline to accommodate patient requests for an alternative physician when the request is solely the product of prejudice against the physician's personal characteristics. (e) Consider accommodating a patient's request for an alternative physician when the request derives from the patient's adverse personal experience, doing so would promote effective care, and another appropriately qualified physician is available to provide the needed care. (f) In emergency situations, patients who persist in opposing treatment from the physician assigned may be helped to seek care from other sources. When transfer is not feasible, patients should be informed that care will be provided by appropriately qualified staff independent of the patient's expressed preference. (~~c~~g) Terminate the patient-physician relationship with a patient ~~who uses derogatory language or acts in a prejudiced manner~~ whose volitional behavior is disrespectful, derogatory, or prejudiced only if the patient will not modify the conduct. In such cases, the physician should arrange to transfer the patient's care when that is feasible. Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to: (h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.

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			(i) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed. (j) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients. (k) Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community.
.Con	Res. 001	MSS	Support for the Use of Psychiatric Advance Directives RESOLVED, That our American Medical Association support efforts to increase awareness and appropriate utilization of psychiatric advance directives. (New HOD Policy)
.Con	Res. 002	MSS	Endorsing the Creation of a Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) Research IRB Training RESOLVED, That our American Medical Association work with appropriate stakeholders to support the creation of model training for Institutional Review Boards to use and/or modify for their unique institutional needs as it relates to research collecting data on Lesbian, Gay, Bi-sexual, Transgender and Queer populations. (Directive to Take Action)
.Con	Res. 003	MSS	Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities RESOLVED, That our American Medical Association amend Policy H-315.996 by addition to read as follows: Accuracy in Racial, Ethnic, Lingual, and Religious Designations in Medical Records, H-315.996 The AMA advocates precision in racial, ethnic, preferred language, and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy of the patient (Modify Current HOD Policy); and be it further RESOLVED, That our AMA encourage the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race and ethnicity. (Directive to Take Action)
.Con	Res. 004	MSS	Improving Inclusiveness of Transgender Patients Within Electronic Medical Record Systems

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			RESOLVED, That our AMA amend Policy H-315.967, "Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation," by addition and deletion to read as follows: Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, H-315.967 Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, ~~and~~ preferred gender pronoun(s), preferred name, and an inventory of current anatomy in medical documentation and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner and (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians. (Modify Current HOD Policy)
.Con	Res. 005	MSS	Removing Sex Designation from the Public Portion of the Birth Certificate RESOLVED, That our American Medical Association advocate for the removal of sex as a legal designation on the public portion of the birth certificate and that it be visible for medical and statistical use only. (Directive to Take Action)
.Con	Res. 006	MSS	Transparency Improving Informed Consent for Reproductive Health Services RESOLVED, That our American Medical Association work with relevant stakeholders to establish a list of Essential Reproductive Health Services (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for legislation requiring healthcare organizations to clearly publish online and in points of service which Essential Reproductive Health Services are available at the organization along with any restrictions on Essential Reproductive Health Services at the institution, and include referral information to patients of other providers that cover the services within the same coverage area. (Directive to Take Action)
.Con	Res. 007	MSS	Addressing the Racial Pay Gap in Medicine RESOLVED, That our American Medical Association support measures of racial pay awareness and the specific challenges that minority physicians face in regards to equal pay financial attainment (New HOD Policy); and be it further

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			RESOLVED, That our AMA support efforts to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries and race of medical physicians. (New HOD Policy)
.Con	Res. 008**	MSS	Improving the Health and Safety of Consensual Sex Workers RESOLVED, That our American Medical Association recognize the adverse health outcomes of criminalizing consensual sex work. (New HOD Policy)
.Con	Res. 009	Delegates	Data for Specialty Society Five-Year Review RESOLVED, That American Medical Association policy G-600.020, "Admission of Specialty Organizations to our AMA House," item 6, be amended by addition and deletion to read as follows: The organization must have a voluntary membership and must report as members only those physician members who are current in payment of applicable dues, ~~have full voting privileges~~, and eligible to serve on committees or the governing body ~~hold office~~. (Modify Current HOD Policy)
.Con	Res. 010	Michigan	Ban Conversion Therapy of LGBTQ Youth RESOLVED, That our American Medical Association advocate for federal legislation to ban conversion therapy. (Directive to Take Action)
.Con	Res. 011	Michigan	End Child Marriage RESOLVED, That our American Medical Association oppose the practice of child marriage (New HOD Policy); and be it further RESOLVED, That our AMA advocate for the passage of state and federal legislation to end the practice of child marriage. (Directive to Take Action)
B	214	New York	AMA Should Provide a Summary of Its Advocacy Efforts on Surprise Medical Bills RESOLVED, That our American Medical Association Board of Trustees provide a detailed report of its efforts and those of allies and opponents around the issue of surprise medical bills in 2019; this discussion should include the following points comparing the AMA and partners activity vs that of its opponents (the insurance companies): 1) What testimony was provided at various committee meetings? 2) What letters were written to various legislators?

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			3) What grass roots efforts were performed? 4) What other groups supported the efforts 5) What other groups were recruited to support the efforts? 6) What media efforts were performed? 7) What television ads were run? 8) What radio ads were run? 9) What print ads were run? 10) What op-ed pieces were run, in national journals, Washington journals, and regional publications? 11) What meetings occurred with various legislators? 12) What meetings occurred with members of the administration? 13) How much money was spent on the various efforts? 14) What studies were published in insurance journals, medical journals, and other journals on this matter? 15) Which senators and representatives and administration members could either side count on as solid supporters? 16) What level of collaboration was there with other national, state, and specialty societies and how was this carried out? (Directive to Take Action)
B	BOT 01	n/a	Legalization of the Deferred Action for Legal Childhood Arrival (DALCA) The Board recommends that our AMA amend Policy D-255.979, "Permanent Residence Status for Physicians on H1-B Visas," by addition to read as follows, in lieu of Resolution 205-I-18 and that the remainder of the report be filed: Our AMA will work with all relevant stakeholders to: 1) clear the backlog for conversion from H1-B visas for physicians to permanent resident status, and 2) allow the children of H-1B visa holders, who have aged out of the H-4 non-immigrant classification, to remain in the U.S. legally while their parents' green card applications are pending. (Modify Current HOD Policy)
B	BOT 02	n/a	Enabling Methadone Treatment of Opioid Use Disorder in Primary Care Settings 1. That our American Medical Association (AMA) support further research into how primary care practices can implement MAT into their practices and disseminate such research in coordination with primary care specialties; (New HOD Policy) 2. That our AMA support efforts to expand primary care services to patients receiving methadone maintenance therapy (MMT) for patients receiving care in an Opioid Treatment Program or via office-based therapy; (New HOD Policy)

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			3. That the AMA Opioid Task Force increase its evidence-based educational resources focused on MMT and publicize those resources to the Federation. (Directive to Take Action)
B	BOT 03	n/a	Restriction on IMG Moonlighting The Board recommends that our American Medical Association not adopt Resolution 204-I-18, "Restriction on IMG Moonlighting," and that the remainder of the report be filed.
B	BOT 09	n/a	Opioid Mitigation 1. That our American Medical Association (AMA) encourage relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and that the AMA share that information with the Federation; (Directive to Take Action) 2. That our AMA update model state legislation regarding needle and syringe exchange to state and specialty medical societies; (Directive to Take Action) 3. That our AMA amend Policy H-100.955, "Support for Drug Courts;" Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; ~~and~~ (2) encourages legislators to establish drug courts at the state and local level in the United States~~.~~; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy) 4. That our AMA urge state and federal policymakers to enforce applicable mental health and substance use disorder parity laws; (Directive to Take Action) 5. That our AMA reaffirm Policy H-95.932, "Increasing Availability of Naloxone;" and (Reaffirm HOD Policy) 6. That our AMA reaffirm Policy D-95.981, "Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction." (Reaffirm HOD Policy)
B	Res. 201	MSS	Advocating for the Standardization and Regulation of Outpatient Addiction Rehabilitation Facilities

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			RESOLVED, That our American Medical Association advocate for the expansion of federal regulations of outpatient addiction rehabilitation centers in order to provide patient and community protection in line with evidence-based care. (Directive to Take Action)
B	Res. 202	MSS	Support for Veterans Courts RESOLVED, That our American Medical Association support the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder. (New HOD Policy)
B	Res. 203	MSS	Support Expansion of Good Samaritan Laws RESOLVED, That our AMA amend Policy D-95.977 by addition and deletion to read as follows: 911 Good Samaritan Laws, D-95.977 Our AMA: (1) will support and endorse policies and legislation that provide protections for callers or witnesses seeking medical help for overdose victims; ~~and~~ (2) will promote 911 Good Samaritan policies through legislative or regulatory advocacy at the local, state, and national level; and (3) will work with the relevant organizations and state societies to raise awareness about the existence and scope of Good Samaritan Laws. (Modify Current HOD Policy)
B	Res. 204	New York	AMA Position on Payment Provisions in Health Insurance Policies RESOLVED, That our American Medical Association seek legislation to ban anti-assignment provisions in health insurance plans (Directive to Take Action); and be it further RESOLVED, That our AMA support legislation requiring health insurers to issue payment directly to the physician when the patient or patient representative signs an agreement which permits payment directly to the physician. (Directive to Take Action)
B	Res. 205	Virginia	Co-Pay Accumulators RESOLVED, That our American Medical Association develop model state legislation based on the recent law enacted in Virginia regarding Co-Pay Accumulators. (Directive to Take Action)
B	Res. 206	IMG	Improvement of Healthcare Access in Underserved Areas by Retaining and Incentivizing IMG Physicians RESOLVED, That our American Medical Association support efforts to retain and incentivize international medical graduates serving in federally designated health professional shortage areas after the current allocated period. (Directive to Take Action).

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
B	Res. 207	MSS	Pharmaceutical Advertising in Electronic Health Record Systems RESOLVED, That our American Medical Association encourage the Centers for Medicare and Medicaid Services to study the effects of direct-to-physician advertising at the point of care, including advertising in Electronic Health Record Systems (EHRs), on physician prescribing, patient safety, health care costs, and EHR access for small practices (Directive to Take Action); and be it further RESOLVED, That our AMA study the ethics of direct-to-physician advertising at the point of care, including advertising in EHRs. (Directive to Take Action)
B	Res. 208	MSS	Net Neutrality and Public Health RESOLVED, That our American Medical Association advocate for policies that ensure internet service providers transmit essential healthcare data no slower than any other data on that network (Directive to Take Action); and be it further RESOLVED, That our AMA collaborate with the appropriate governing bodies to develop guidelines for the classification of essential healthcare data requiring preserved transmission speeds (Directive to Take Action); and be it further RESOLVED, That our AMA oppose internet data transmission practices that reduce market competition in the health ecosystem. (Directive to Take Action)
B	Res. 209	ASTS	Federal Government Regulation and Promoting Patient Access to Kidney Transplantation RESOLVED, That our American Medical Association engage US government regulatory and professional organ transplant organizations to advance patient and physician-directed care for End Stage Renal Disease (ESRD) patients (Directive to Take Action); and be it further RESOLVED, That our AMA actively promote regulatory efforts to assure physician and patient involvement in the design of any ESRD federal demonstration program (Directive to Take Action); and be it further RESOLVED, That our AMA actively advocate for legislative and regulatory efforts which create incentives for dialysis providers, transplant centers, organ donors, and ESRD patients to increase organ donation and improve access to kidney transplantation in the United States. (Directive to Take Action)
B	Res. 210	ASTS	Federal Government Regulation and Promoting Renal Transplantation

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			RESOLVED, That our American Medical Association actively advocate for US organ transplant legislative and regulatory policies that would advance kidney transplantation by modifying or eliminating arbitrary transplant center outcomes measures that currently discourage sound clinical judgment by physicians and surgeons to accept and transplant kidneys suitable for many patients. (Directive to Take Action)
B	Res. 211	Michigan	Effects of Net Neutrality on Public Health RESOLVED, That our American Medical Association amend current policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health Disparities," by addition and deletion as follows: Increasing ~~Access to Broadband~~ Internet Access to Reduce Health Disparities Our AMA: (1) will advocate for net neutrality; and (2) will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. (Modify Current HOD Policy)
B	Res. 212	Michigan	Centers for Medicare and Medicaid Services Open Payments Program RESOLVED, That our American Medical Association amend current policy H-140.848, "Physician Payments Sunshine Act," by addition and deletion to read as follows: Our AMA will: (1) continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by the Centers for Medicare & Medicaid Services (CMS) and will recommend to the CMS that a physician comment section be included on the "Physician Payments Sunshine Act" public database; (2) lobby Congress to amend the Sunshine Act to limit transfer of value reporting to items with a value of greater than $100; (3) advocate that: (a) (i) any payment or transfer of value reported as part of the Physician Payments Sunshine Act should include whether the physician acknowledged receipt of said payment or transfer of value, and (ii) each payment or transfer of value on the Open Payments website indicates whether the physician verified the payment or transfer of value; and (b) a contested reported payment or transfer of value should be removed immediately from the Open Payments website until the reporting company validates the compensation with verifiable documentation; ~~and~~ (4) support significant modifications to the Sunshine Act, such as substantially increasing the monetary threshold for reporting, that will decrease the regulatory and administrative burden on physicians, protect physician rights to challenge false and misleading reports, change the dispute process so that successfully disputed charges are not included publicly on the Open Payments database, and provide a meaningful, accurate picture of the physician-industry relationship; (5) urge the Centers for Medicare and Medicaid Services to expand the definition of "covered recipients" to include pharmacists and Pharmacy Benefit Managers; and (6) continue to educate physicians about the Sunshine Act and its implications in light of publicly available data on the Centers of Medicare and Medicaid (CMS) Open Payments Program website. (Modify Current HOD Policy)

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
B	Res. 213	Colorado	Data Completeness and the House of Medicine RESOLVED, That our American Medical Association amend section 4 of policy D-155.987, "Price Transparency," by addition to read as follows: 4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases. (Modify Current HOD Policy); and be it further RESOLVED, That our AMA direct its advocacy team to work with the National Academy for State Health Policy (NASHP), the All-Payer Claims Database Council (APCD Council), the National Association of Health Data Organizations (NAHDO), and other interested organizations to speed promulgation of final rule making as regards Schedule J by the Department of Labor (DOL) in matters related to the *Gobeille v. Liberty Mutual Insurance Company* decision (Directive to Take Action); and be it further RESOLVED, That, in supporting a rule making process by the DOL in matters related to the *Gobeille v. Liberty Mutual Insurance Company* decision, our AMA support the adoption of a standardized set of health care claims data such as the Common Data Layout, support that any DOL requirement for plans to submit health care claims data must be tied to current rule making processes (such as its proposed Schedule J), and support that the DOL implement a pilot program to collect health care claims data in cooperation with state APCDs. (Directive to Take Action)
C	CME 02	n/a	Healthcare Finance in the Medical School Curriculum That our American Medical Association (AMA) amend Policy H-295.924, "Future Directions for Socioeconomic Education," by addition and deletion to read as follows: "The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools and residencies to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented ~~in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings,~~ at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage ~~representatives to~~ the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum." (Modify Current HOD Policy)
C	CME 03	n/a	Standardization of Medical Licensing Time Limits Across States

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			1. That our American Medical Association (AMA) urge the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams to allow sufficient time for individuals who are pursuing combined degrees (e.g, MD/PhD). (New HOD Policy) 2. That our AMA urge that state medical and osteopathic licensing boards with time limits for completing the licensing examination sequence provide for exceptions that may involve personal health/family circumstances. (New HOD Policy) 3. That our AMA encourage uniformity in the time limit for completing the licensing examination sequence across states, allowing for improved inter-state mobility for physicians. (New HOD Policy)
C	CME 04	n/a	Board Certification Changes Impact Access to Addiction Medicine Specialists 1. That our American Medical Association (AMA) recognize the American Board of Preventive Medicine (ABPM) for developing and providing pathways for all qualified physicians to obtain ABMS-approved certification in the new ABPM subspecialty of addiction medicine, in order to improve access to care for patients with substance use disorder. (Directive to Take Action) 2. That our AMA rescind Policy H-300.962 (3) “Recognition of Those Who Practice Addiction Medicine,” since the ABPM certification examination in addiction medicine is now offered. (Rescind HOD Policy)
C	CME 06	n/a	Veterans Health Administration Funding of Graduate Medical Education 1. That our AMA support postgraduate medical education service obligations through any program where the expectation for service is explicitly delineated in the contract with the trainee. (New HOD Policy) 2. That our American Medical Association (AMA) oppose the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training. (New HOD Policy)
C	Res. 301	MSS	Engaging Stakeholders for Establishment of a Two-Interval, or Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools RESOLVED, That our American Medical Association amend Policy H-295.866 by addition and deletion to read as follows:

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			Supporting Two-Interval Grading Systems for Medical Education, H-295.866 Our AMA will work with stakeholders to encourage the establishment of ~~acknowledges the benefits of~~ a two-interval grading system in medical colleges and universities in the United States for the non-clinical curriculum. (Modify Current HOD Policy)
C	Res. 302	MSS	Strengthening Standards for LGBTQ Medical Education RESOLVED, That our AMA amend policy H-295.878, "Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education," by addition and deletion to read as follows: Eliminating Health Disparities – Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues, H-295.878 Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include Lesbian, Gay, Bisexual, Transgender and Queer health issues in the basic science, clinical care, and cultural competency ~~curriculum~~ curricula for both undergraduate and graduate medical education; and (4) encourages the Liaison Committee on Medical Education (LCME), American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical Education (ACGME) to periodically reassess the current status of curricula for medical student and residency education addressing the needs of ~~pediatric and adolescent~~ Lesbian, Gay, Bisexual, Transgender and Queer patients. (Modify Current HOD Policy)
C	Res. 303	MSS	Investigation of Existing Application Barriers for Osteopathic Medical Students Applying for Away Rotations RESOLVED, That our American Medical Association work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting. (Directive to Take Action)
C	Res. 304	Indiana	Issues with the Match, the National Residency Matching Program (NRMP) RESOLVED, That our American Medical Association redouble its efforts to promote an increase in residency program positions in the U.S. (Directive to Take Action); and be it further

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			RESOLVED, That our AMA assign an appropriate AMA committee or committees to: - Study the issue of why residency positions have not kept pace with the changing physician supply and investigate what novel residency programs have been successful across the country in expanding positions both traditionally and nontraditionally. - Seek to determine what causes a failure to match and better understand what strategies are most effective in increasing the chances of a successful match, especially after a prior failure. The committee(s) would rely upon the BNRMP (Board of the National Residency Matching Program) to provide some of this information through surveys, questionnaires and other means. Valid data would be valuable to medical students who seek to improve their chances of success in The Match. - Report back to the AMA HOD with findings and recommendations (Directive to Take Action); and be it further RESOLVED, Because SOAP (Supplemental Offer and Acceptance Program) failed to adequately serve some physicians seeking to match this year, that our AMA support the option to allow individuals participating in one future Match at no cost (Directive to Take Action); and be it further RESOLVED, That in order to understand the cost of The Match and identify possible savings, our AMA encourage the Board of the National Residency Matching Program to: 1. Conduct an independent and fully transparent audit of SOAP (Supplemental Offer and Acceptance Program) to identify opportunities for savings, with the goal of lowering the financial burden on medical students and new physicians 2. Actively promote success for those participating in The Match by better explaining and identifying those issues that interfere with the successful match and to offer strategies to mitigate those issues. This information can be disseminated through the program website and through services such as its “Help” and “Q&A” links, and also through the AMA. (Directive to Take Action)
C	Res. 305	YPS	Ensuring Access to Safe and Quality Care for our Veterans RESOLVED, That our American Medical Association amend AMA Policy H-510.986, “Ensuring Access to Care for our Veterans,” by addition to read as follows: Ensuring Access to Safe and Quality Care for our Veterans H-510.986 1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner. 3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans. 4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration. 5. Our AMA supports access to similar clinical educational resources for all health care professionals involved in the care of veterans as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans. 6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed. (Modify HOD Policy)
C	Res. 306	Indiana	Financial Burden of USMLE Step 2 CS on Medical Students RESOLVED, That our American Medical Association work with the Federation of State Medical Boards/United States Medical Licensing Examination (USMLE) to reduce the cost of the USMLE Step 2 CS exam and allow medical students to take this exam locally to defray unnecessary expenses. (Directive to Take Action)
C	Res. 307	IMG	Implementation of Financial Education Curriculum for Medical Students and Physicians in Training RESOLVED, That our American Medical Association work with relevant stakeholders to study the development of a curriculum during medical school and residency/fellowship training to educate them about the financial and business aspect of medicine. (Directive to Take Action)
C	Res. 308	New England	Study Expediting Entry of Qualified IMG Physicians to US Medical Practice RESOLVED, That our American Medical Association study and make recommendations for the best means for evaluating, credentialing and expediting entry of competently trained international medical graduate (IMG) physicians of all specialties into medical practice in the USA. (Directive to Take Action)
F	BOT 06	n/a	Physician Health Policy Opportunity

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			1. That our American Medical Association encourage and support efforts to educate interested medical students, residents, fellows, and practicing physicians about health policy and assist them in starting or transitioning to careers that involve health policy. (New HOD Policy) 2. That our AMA significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy fellowship opportunities and help them to apply for and participate in them. (Directive to Take Action) 3. That our AMA engage with alumni of health policy fellowship programs and joint degree programs and provide opportunities for them to share their health policy experiences with medical students, residents, fellows, and practicing physicians. (Directive to Take Action) 4. That our AMA include health policy content in its educational resources for members. (Directive to Take Action) 5. That our AMA work with the Office of the U.S. Surgeon General to disseminate information to medical students, residents, fellows, and practicing physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service. (Directive to Take Action)
F	BOT 08	n/a	Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership That our American Medical Association continue to explore environmentally sustainable practices for *JAMA* distribution.
F	BOT 10	n/a	Childcare at AMA HOD Meetings 1. That Policy D-600.958 be rescinded, as the pilot program has concluded. (Rescind HOD Policy) 2. That our American Medical Association continue to coordinate childcare at its annual and interim meetings for interested parent or guardian attendees and provide a room in the meeting venue or hotel for use by these childcare providers. (Directive to Take Action)
F	CLRPD 01	n/a	Academic Physicians Section Five-Year Review The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Academic Physicians Section through 2024 with the next review no later than the 2024 Interim Meeting. (Directive to Take Action)

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
F	Res. 601**	MSS	Amending AMA Policy G-630.140, “Lodging, Meeting Venues, and Social Functions” RESOLVED, That our American Medical Association amend Policy G-630.140, “Lodging, Meeting Venues, and Social Functions,” be amended by addition to read as follows: Lodging, Meeting Venues, and Social Functions, G-630.140 1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. 2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity. 3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy. 4. It is the policy of our AMA not to hold national meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy. 5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping. (Reaffirm HOD Policy)
J	CMS 01	n/a	Established Patient Relationships and Telemedicine 1. That our American Medical Association (AMA) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services. (Directive to Take Action) 2. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including that physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services. (Reaffirm HOD Policy) 3. That our AMA reaffirm Policy H-480.969, which maintains that state medical boards should require a full and unrestricted license in that state for the practice of telemedicine, with no differentiation by specialty, unless there are other appropriate state-based licensing methods, and with exemptions for emergent or urgent circumstances and “curbside consultations.” (Reaffirm HOD Policy)

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
J	CMS 02	n/a	Addressing Financial Incentives to Shop for Lower-Cost Health Care 1. That our American Medical Association (AMA) support the following continuity of care principles for any financial incentive program (FIP): a) Collaborate with the physician community in the development and implementation of patient incentives. b) Collaborate with the physician community to identify high-value referral options based on both quality and cost of care. c) Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options. d) Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service. e) Provide referring and/or primary care physicians with the full record of the service encounter. f) Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan). g) Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans. (New HOD Policy) 2. That our AMA support the following quality and cost principles for any FIP: a) Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits. b) Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities. c) Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. d) Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians. e) Provide a process through which patients and physicians can publicly report unsatisfactory care experiences with referred lower-cost physicians or facilities. f) Provide meaningful transparency of prices and vendors. g) Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities. h) Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs. (New HOD Policy)

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			3. That our AMA support requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services. (New HOD Policy) 4. That our AMA oppose FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice. (New HOD Policy) 5. That our AMA encourage state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices. (New HOD Policy) 6. That our AMA encourage objective studies of the impact of FIPs that include data collection on dimensions such as: a) Patient outcomes/the quality of care provided with shopped services; b) Patient utilization of shopped services; c) Patient satisfaction with care for shopped services; d) Patient choice of health care provider; e) Impact on physician administrative burden; and f) Overall/systemic impact on health care costs and care fragmentation. (New HOD Policy)
J	CMS 03	n/a	Improving Risk Adjustment in Alternative Payment Models 1. That our American Medical Association (AMA) reaffirm Policy H-385.908 stating that the AMA will work with the Centers for Medicare & Medicaid Services and interested organizations to design systems that identify data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors; account for differences in patient needs, such as functional limitations, changes in medical conditions, and ability to access health care services; and explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification. (Reaffirm HOD Policy) 2. That our AMA reaffirm Policy D-478.995 advocating for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records so that capturing patient characteristics and risk adjustment measures do not add to physician and practice administrative burden. (Reaffirm HOD Policy)

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			3. That our AMA support risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications. (New HOD Policy) 4. That our AMA support risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost. (New HOD Policy) 5. That our AMA support risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost. (New HOD Policy) 6. That our AMA support risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control. (New HOD Policy) 7. That our AMA support accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence. (New HOD Policy)
J	CMS 04	n/a	Mechanisms to Address High and Escalating Pharmaceutical Prices 1. That our American Medical Association (AMA) advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation: a. The arbitration process should be overseen by objective, independent entities; b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel; c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process; d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question; e. The arbitration process should include the submission of a value-based price benchmark for the drug in question to inform the arbitrator's decision; f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer/government entity; g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases; and

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			h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision. (New HOD Policy) 2. That our AMA advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles: a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls; b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation; c. The use of any international drug price index or average should preserve patient access to necessary medications; and d. The use of any international drug price index or average should limit burdens on physician practices. (New HOD Policy) 3. That our AMA support the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction. (New HOD Policy) 4. That our AMA reaffirm Policy H-110.983, which advocates that any revised Medicare Part B Competitive Acquisition Program meet certain outlined standards to improve the value of the program by lowering the cost of drugs without undermining quality of care. (Reaffirm HOD Policy) 5. That our AMA reaffirm Policy H-110.986, which outlines principles for value-based pricing programs, initiatives and mechanisms for pharmaceuticals, and supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. (Reaffirm HOD Policy) 6. That our AMA reaffirm Policy H-460.909, which outlines principles for creating a centralized comparative effectiveness research entity. (Reaffirm HOD Policy) **7.** That our AMA reaffirm Policy D-330.954, which states that our AMA will work toward eliminating Medicare prohibition on drug price negotiation. (Reaffirm HOD Policy)
J	Res. 801	MSS	Reimbursement for Post-Exposure Protocol for Needlestick Injuries RESOLVED, That our American Medical Association encourage medical schools to ensure medical students can be reimbursed for the costs associated with post-exposure protocol for blood or body substance exposure sustained during clinical rotations either by their insurance provider or the state's workers' compensation fund, where applicable (Directive to Take Action); and be it further

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			RESOLVED, That our AMA encourage state societies to work with their respective workers' compensation fund to include medical students as recipients of medical benefits in the event of blood or body substance exposure during clinical rotations. (Directive to Take Action)
J	Res. 802	MSS	Ensuring Fair Pricing of Drugs Developed with the United States Government RESOLVED, That our American Medical Association amend Policy H-110.987 by addition to read as follows: Pharmaceutical Costs, H-110.987 1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients. 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug

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			shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment. 11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase. 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency. 13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations. 14. Our AMA will support trial programs using international reference pricing for pharmaceuticals as an alternative drug reimbursement model for Medicare, Medicaid, and/or any other federally-funded health insurance programs, either as in individual solution or in conjunction with other approaches. (Modify Current HOD Policy)
J	Res. 803	MSS	Encourage Federal Efforts to Expand Access to Scheduled Dialysis for Undocumented People RESOLVED, That our American Medical Association support expanded access to scheduled dialysis for undocumented persons with end-stage renal disease. (New HOD Policy)
J	Res. 804	Indiana	Protecting Seniors from Medicare Advantage Plans RESOLVED, That our American Medical Association encourage AARP, insurance companies and other vested parties to develop simplified tools and guidelines for comparing and contrasting Medicare Advantage plans. (New HOD Policy)
J	Res. 805	IMG	Fair Medication Pricing for Patients in United States: Advocating for a Global Pricing Standard RESOLVED, That our American Medical Association advocate for legislation to create an International Pricing Index that would track global medication prices for all prescription medications and keep U.S. medication costs aligned with prices paid in other countries to help control costs and reduce unreasonable patient financial barriers to treatment (Directive to Take Action); and be it RESOLVED, That our AMA advocate for legislation that would ensure that patients are charged fairly for prescription medications based on the International Pricing Index and that additional costs will not be arbitrarily assigned or passed onto patients. (Directive to Take Action)
J	Res. 806	MSS	Support for Housing Modification Policies

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			RESOLVED, That our American Medical Association support legislation for health insurance coverage of housing modification benefits for: (a) the elderly; (b) other populations that require these modifications in order to mitigate preventable health conditions, including but not limited to the disabled or soon to be disabled; and (c) other persons with physical and/or mental disabilities. (New HOD Policy)
J	Res. 807	New England	Addressing the Need for Low Vision Aid Devices RESOLVED, That our American Medical Association support legislative and regulatory actions promoting insurance coverage and adequate funding for low vision aids for patients with visual disabilities. (Directive to Take Action)
J	Res. 808	AAPM&R	Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs RESOLVED, That our American Medical Association request that the Centers for Medicare and Medicaid Services (CMS) render a benefit category determination (BCD) that establishes that the seat elevation and standing features of power wheelchairs are primarily medical in nature and qualify under the definition of durable medical equipment (DME) when used in a power wheelchair (Directive to Take Action); and be it further RESOLVED, That our AMA urge CMS to require the DME Medicare Administrative Contractors (MACs) to determine an appropriate coverage policy for Medicare beneficiaries in need of the seat elevation and standing features in their power wheelchairs on an individual basis according to the National Coverage Determination (NCD) for mobility assistance equipment (MAE), activate the existing Healthcare Common Procedure Coding System (HCPCS) codes for seat elevation and standing feature in power wheelchairs, and determine appropriate reimbursement levels for these codes in order to facilitate access to these important benefits for Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further RESOLVED, That if CMS is not able or willing to provide access to seat elevation and standing feature through its administrative authority, our AMA advocate before Congress to support legislation that will clarify the DME benefit to include coverage, coding and reasonable reimbursement of standing feature and seat elevation in power wheelchairs for appropriate Medicare beneficiaries with mobility impairments (Directive to Take Action); and be it further RESOLVED, That our AMA encourage all health insurance carriers to cover standing feature and seat elevation in power wheelchairs for appropriate beneficiaries with mobility impairments. (Directive to Take Action)
J	Res. 809	UT	AMA Principles of Medicaid Reform RESOLVED, That our American Medical Association support the following principles of Medicaid reform: 1. Provide appropriate access to care that is the most cost effective and efficient to our citizens.

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			2. Encourage individuals to be enrolled in private insurance supported by Medicaid funding, if possible. 3. Create the best coverage at the lowest possible cost. 4. Incentivize Medicaid patient behavior to improve lifestyle, health, and compliance with appropriate avenues of care and utilization of services. 5. Establish a set of specialty specific high-quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care. 6. Seek to establish improved access for Medicaid patients to primary care providers and referrals to specialists for appropriate care. 7. Assure appropriate payment and positive incentives to encourage but not require clinician participation in Medicaid for both face-to-face and non-face-to-face encounters, under appropriate establishment of clinician-patient relationship. 8. Include payment incentives to clinicians for after-hours primary care to assist patients with an inability to access care during normal business hours. 9. Avoid tactics and processes that inhibit access to care, delay interventions and prevent ongoing maintenance of health. 10. Eliminate current disincentives (e.g., Medicaid spend-down in order to qualify) to patients improving their lives while on Medicaid, to increase successful transition into the private insurance market. 11. Cease any tax, or attempt to tax, any health care profession for the purpose of supporting the cost of Medicaid. 12. Develop a physician directed clinician oversight board at the state level to insure the proper access, quality and cost of care under the Medicaid program throughout all geographically diverse areas of the states. 13. Allow clinicians to see patients for more than one procedure in a visit so that patients do not have to return for another service at an extra cost to the Medicaid program and extra time and effort to the Medicaid patient (e.g., if patient comes because they are sick, allow them to have a diabetes check-up at the same time). 14. Strategically plan to reduce administrative costs and burdens to clinicians, and of the Medicaid program itself, by reducing at least, but not limited to, burdensome documentation requirements, administrative obstacles, and regulatory impediments. (New HOD Policy) and be it further RESOLVED, That our AMA pursue action to improve the federal requirements for Medicaid programs based on the AMA's principles of Medicaid reform (Directive to Take Action)
J	Res. 810	UT	Hospital Medical Staff Policy RESOLVED, That our American Medical Association support and advocate that hospital medical staff leadership should be fully licensed physicians and that if others are included, they should be non-voting or advisory to the hospital medical staff members (Directive to Take Action); and be it further RESOLVED, That our AMA support and advocate that the decisions made by hospital medical staffs focus on quality patient care, medical staff standards and the operation of the hospital, and that those decisions not engage

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			the medical staff in external political matters (e.g., advanced practice clinician scope of practice expansion, etc.). (Directive to Take Action); and be it further RESOLVED, That AMA Policy H-225.993, "Medical Staff Policy Determination," be rescinded. (Rescind HOD Policy)
J	Res. 811	Michigan	Require Payers to Share Prior Authorization Cost Burden RESOLVED, That our American Medical Association reaffirm policies H-320.939, "Prior Authorization and Utilization Management Reform," and H-385.951, "Remuneration for Physician Services." (Reaffirm HOD Policy)
K	CSAPH 01	n/a	Mandatory Reporting of Diseases and Conditions Public Health Surveillance That our AMA: (1) recognizes public health surveillance as a core public health function that is essential to inform decision making, identify underlying causes and etiologies, and respond to acute, chronic, and emerging health threats; (2) recognizes the important role that physicians play in public health surveillance through reporting diseases and conditions to public health authorities; (3) encourages state legislatures to engage relevant state and national medical specialty societies as well as public health agencies when proposing mandatory reporting requirements to ensure they are based on scientific evidence and meet the needs of population health; (4) recognizes the need for increased federal funding to modernize our nation's public health data systems to improve the quality and timeliness of data; (5) supports electronic case reporting, which alleviates the burden of case reporting on physicians through the automatic generation and transmission of case reports from electronic health records to public health agencies for review and action in accordance with applicable health care privacy and public health reporting laws; (6) will share updates with physicians and medical societies on public health surveillance and the progress made toward implementing electronic case reporting. (New HOD Policy)
K	CSAPH 02	n/a	Real-World Data and Real-World Evidence in Medical Product Decision Making The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed: 1. Our AMA supports the generation and use of real-world data (RWD) and real-world evidence (RWE) fit for regulatory purpose to: (a) evaluate effectiveness and safety of medical products, while assuring patient privacy and confidentiality; (b) improve regulatory decision-making; (c) decrease medical product costs; (d) increase research efficiency; (e) advance innovative and new models of drug development; and (f) improve clinical care and patient outcomes. (New HOD Policy)

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			2. Our AMA supports the aim of the U.S. Food and Drug Administration (FDA) to expand and clarify the use RWD and RWE in regulatory decision-making including in: a. understanding the potential of RWE to meet the established standards for adequate and well-controlled clinical investigations; b. pursuing the integration of RWE into medical product development and regulatory review; and c. utilizing RWE to support new indications for approved medical products, and its ability to satisfy post-approval study requirements. (New HOD Policy) 3. Our AMA supports that there be adequate funding of data infrastructure to allow for transparent data management capabilities, improved access to data by clinicians, especially physicians, as well as researchers and other stakeholders, and improved reliability and relevance of data. (New HOD Policy) 4. Our AMA supports cooperation and collaboration of stakeholders to facilitate the collection and use of RWD and RWE that is deemed fit for regulatory purpose. (New HOD Policy) 5. Our AMA will evaluate and develop a response to the educational needs of physicians seeking to understand the use of fit for purpose RWD and RWE in clinical practice. (New HOD Policy) 6. That Policy H-100.992, “FDA,” be amended by addition to read as follows: H-100.992, “FDA” (1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications. (2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation. (3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. (Modify Current HOD Policy)

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			7. That Policy D-100.982, “Enhanced Physician Access to Food and Drug Administration Data,” urging the FDA to apply new tools to gather data after drugs are approved for marketing, including a broader use of targeted post-approval studies, institution of active and sentinel event surveillance, and data mining of available drug utilization databases, be reaffirmed. (Reaffirm Current HOD Policy) 8. That Policy H-110.986, “Incorporating Value into Pharmaceutical Pricing” supporting value-based pricing of pharmaceuticals that is evidence-based and the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes, be reaffirmed. (Reaffirm Current HOD Policy) 9. That Policy H-406.987, “Medical Information and Its Uses,” identifying three components of a data transparency framework, be reaffirmed. (Reaffirm Current HOD Policy) 10. That Policy H-410.948, “Clinical Pathways,” supporting the development of transparent, collaboratively constructed clinical pathways that are implemented in ways that promote administrative efficiencies for both providers and payers; promote access to evidence-based care for patients; recognize medical variability among patients and individual patient autonomy; promote access to clinical trials; and are continuously updated to reflect the rapid development of new scientific knowledge, be reaffirmed. (Reaffirm Current HOD Policy) 11. That Policy H-450.933, “Clinical Data Registries,” encouraging multi-stakeholder efforts to develop and fund clinical data registries to facilitate quality improvements and research that results in better health care, improved population health, and lower costs be reaffirmed. (Reaffirm Current HOD Policy) 12. That Policy D-460.970, “Access to Clinical Trial Data,” urging the FDA to investigate and develop means by which scientific investigators can access original source safety data from industry-sponsored trials upon request; be reaffirmed. (Reaffirm Current HOD Policy)
K	CSAPH 03	n/a	Patient Use of Non-FDA Approved Cannabis and Cannabinoid Products in Hospitals The Council recommends that the following recommendation be adopted in lieu of Resolution 414-A-19, and the remainder of the report be filed.

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			The AMA encourages hospitals and health systems to: (1) engage stakeholders, including, but not limited to physicians, nurses, pharmacists, legal counsel, experts in controlled substance diversion prevention, as well as relevant state and federal agencies in developing policies for addressing patient use of non-FDA approved cannabis or cannabis-derived products for use within their facilities and (2) communicate their policy on patient use of non-FDA approved cannabis or cannabis-derived products within their facilities, to ensure clinicians are prepared to treat patients in accordance with policy. (New HOD Policy)
K	Res. 901	MSS	Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water RESOLVED, That our American Medical Association support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of Per- and Polyfluoroalkyl substances. (New HOD Policy)
K	Res. 902	MSS	Amending H-490.913, "Smoke-Free Environments and Workplaces," and H-490.907, "Tobacco Smoke Exposure of Children in Multi-Unit Housing," to Include E-Cigarettes RESOLVED, That our American Medical Association amend policy H-490.913, "Smoke-Free Environments and Workplaces," by addition and deletion to read as follows: Smoke-Free and Vape-Free Environments and Workplaces, H-490.913 On the issue of the health effects of environmental tobacco smoke (ETS), ~~and~~ passive smoke, and vape exposure in the workplace and other public facilities, our AMA: (1)(a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws. (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping

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			campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe, cigar, and e-cigarette smoking in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) encourages and supports local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues (Modify Current HOD Policy); and be it further RESOLVED, That our AMA amend Policy H-490.907, “Tobacco Smoke Exposure of Children in Multi-Unit Housing,” to include e-cigarettes and vaping by addition to read as follows: Tobacco Smoke and Vaping Exposure of Children in Multi-Unit Housing, H-490.907 Our AMA: (1) encourages federal, state and local housing authorities and governments to adopt policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			smoking and vaping in multi-unit housing; and (2) encourages state and local medical societies, chapters, and other health organizations to support and advocate for changes in existing state and local laws and policies that protect children and non-smoking or non-vaping adults from tobacco smoke and vaping exposure by prohibiting smoking and vaping in multi-unit housing. (Modify Current HOD Policy)
K	Res. 903	MSS	Encouraging the Development of Multi-Language, Culturally Informed Mobile Health Applications RESOLVED, That AMA amend policy D-480.972 by addition to read as follows: Guidelines for Mobile Medical Applications and Devices, D-480.972 1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement. 2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market. 3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence-based. 4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications. 5. Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents and fellows. 6. Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training. 7. Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments. 8. Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed content catered to underserved and low-income populations. (Modify Current HOD Policy)
K	Res. 904	MSS	Amendment to AMA Policy H-150.949, “Healthy Food Options in Hospitals” RESOLVED, That our AMA encourage the availability of healthy, plant-based options at medical care facilities by amending AMA Policy H-150.949, “Healthy Food Options in Hospitals,” by addition and deletion to read as follows: Healthy Food Options in ~~Hospitals~~ Medical Care Facilities, H-150.949

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on ~~hospital~~ the premises of Medical Care Facilities. 2. Our AMA hereby calls on ~~US hospitals~~ all Medical Care Facilities and Correctional Facilities to improve the health of patients, staff, and visitors by: (a) providing a variety of healthy food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthy beverages. 3. Our AMA hereby calls for ~~hospital~~ Medical Care Facility cafeterias and inpatient meal menus to publish nutrition information. (Modify Current HOD Policy)
K	Res. 905	MSS	Sunscreen Dispensers in Public Spaces as a Public Health Measure RESOLVED, That our American Medical Association support free public sunscreen programs in public spaces where the population would have a high risk of sun exposure. (New HOD Policy)
K	Res. 906	MSS	Ensuring the Best In-School Care for Children with Sickle Cell Disease RESOLVED, That our American Medical Association support the development of an individualized sickle cell emergency care plan by physicians for in-school use, especially during sickle cell crises (New HOD Policy); and be it further RESOLVED, That our AMA support the education of teachers and school officials on policies and protocols, encouraging best practices for children with sickle cell disease, such as adequate access to the restroom and water, physical education modifications, seat accommodations during extreme temperature conditions, access to medications, and policies to support continuity of education during prolonged absences from school, in order to ensure that they receive the best in-school care, and are not discriminated against, based on current federal and state protections. (New HOD Policy)
K	Res. 907	MSS	Increasing Access to Gang-Related Laser Tattoo Removal in Prison and Community Settings RESOLVED, That our American Medical Association support increased access to gang-related tattoo removal in prison and community settings. (New HOD Policy)
K	Res. 908	MSS	Request for Benzodiazepine-Specific Prescribing Guidelines for Physicians RESOLVED, That our American Medical Association support the creation of national benzodiazepine-specific prescribing guidelines for physicians. (New HOD Policy)
K	Res. 909	RFS	Decreasing the Use of Oximetry Monitors for the Prevention of Sudden Infant Death Syndrome

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			RESOLVED, That our American Medical Association oppose the sale and use of oximetry monitors to prevent sudden infant death syndrome. (New HOD Policy)
K	Res. 910	MAS	Ban on Electronic Nicotine Delivery System (ENDS) Products RESOLVED, That our American Medical Association advocate for regulatory, and/or legislative, and/or legal action at the federal and/or state levels to ban all Electronic Nicotine Delivery Systems (ENDS) products. (Directive to Take Action)
K	Res. 911	YPS	Basic Courses in Nutrition RESOLVED, That our American Medical Association amend Policy H-150.995, “Basic Courses in Nutrition,” by addition to read as follows: Basic Courses in Nutrition H-150.995 1. Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels. 2. Our AMA encourages collaboration with appropriate entities to develop and promote relevant nutrition education to enhance patient care and medical trainee education and wellbeing. 3. Our AMA encourages alignment with evidence-based dietary guidelines for food served in medical trainings and medical conferences. (Modify Current HOD Policy)
K	Res. 912	YPS	Improved Emergency Response Planning for Infectious Disease Outbreaks RESOLVED, That our American Medical Association encourage hospitals and other entities that collect patient encounter data to report syndromic (i.e., symptoms that appear together and characterize a disease or medical condition) data to public health departments in order to facilitate syndromic surveillance, assess risks of local populations for disease, and develop comprehensive plans with stakeholders to enact actions for mitigation, preparedness, response, and recovery (Directive to Take Action); and be it further RESOLVED, That our AMA support flexible funding in public health for unexpected infectious disease to improve timely response to emerging outbreaks and build public health infrastructure at the local level with attention to medically underserved areas (Directive to Take Action); and be it further RESOLVED, That our AMA encourage health departments to develop public health messaging to provide education on unexpected infectious disease. (Directive to Take Action)

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
K	Res. 913	YPS	Public Health Impacts and Unintended Consequences of Legalization and Decriminalization of Cannabis for Medicinal and Recreational Use RESOLVED, That our American Medical Association work with interested organizations to collate existing worldwide data on the public health impacts, societal impacts, and unintended consequences of legalization and/or decriminalization of cannabis for recreational and medicinal use, with a report back at the 2020 Interim Meeting (Directive to Take Action); and be it further RESOLVED, That our AMA continue to encourage research on the unintended consequences of legalization and decriminalization of cannabis for recreational and medicinal use in an effort to promote public health and public safety (Directive to Take Action); and be it further RESOLVED, That our AMA encourage dissemination of information on the public health impacts of legalization and decriminalization of cannabis for recreational and medicinal use, with consideration of making links to that information available on the AMA website (Directive to Take Action); and be it further RESOLVED, That our AMA work with interested organizations to lobby Congress to allow more sites to conduct research on the risks and benefits of cannabinoid products. (Directive to Take Action)
K	Res. 914	Indiana	Nicotine Replacement Therapy for Minors RESOLVED, That our American Medical Association seek immediate and thorough study of the use of all forms of nicotine delivery, as well as all nicotine addiction treatment options in populations under the age of 18 (Directive to Take Action); and be it further RESOLVED, That our AMA support federal regulation that encourages manufacturers of nicotine addiction treatment therapy approved for adults to examine their products' effects in populations under age 18. (Directive to Take Action)
K	Res. 915	ACC	Preventing Death and Disability Due to Particulate Matter Produced by Automobiles RESOLVED, That our American Medical Association promote policies at all levels of society and government that educate and encourage policy makers to limit or eliminate disease causing contamination of the environment by gasoline and diesel combustion-powered automobiles, advocating for the development of alternative means for automobile propulsion and public transportation. (New HOD Policy)
K	Res. 916	ACC	Sale of Tobacco in Retail Pharmacies

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			RESOLVED, That our American Medical Association widely publicize opposition to pharmacies selling tobacco products, especially to minors, and seek active collaboration with other healthcare professionals through their professional organizations, especially pharmacists, but including all healthcare team members, to persuade all retailers of prescription pharmaceuticals to immediately cease selling tobacco products, with a report back at the 2020 Annual Meeting. (Directive to Take Action)
K	Res. 917	MSS	Supporting Research into the Therapeutic Potential of Psychedelics RESOLVED, That our American Medical Association call for the status of psychedelics as Schedule I substances be reclassified into a lower schedule class with the goal of facilitating clinical research and developing psychedelic-based medicines (Directive to Take Action); and be it further RESOLVED, That our AMA explicitly support and promote research into the therapeutic potential of psychedelics to help make a more conducive environment for research, given the high regulatory and cultural barriers (Directive to Take Action); and be it further RESOLVED, That our AMA support and promote research to determine the benefits and adverse effects of long-term psychedelic use. (Directive to Take Action)
K	Res. 918	New England	Banning Flavors, including Menthol and Mint, in Combustible and Electronic Cigarettes and Other Nicotine Products RESOLVED, That our American Medical Association amend Policy H-495.971, "Opposition to Addition of Flavors to Tobacco Products," by addition as follows: Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of <u>all</u> flavored tobacco products, <u>including menthol, mint and wintergreen flavors</u>; (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of <u>all</u> flavored tobacco products; and (3) encourages the FDA to prohibit the use of <u>all</u> flavoring agents in tobacco products, which includes electronic nicotine delivery systems <u>as well as combustible cigarettes, cigars and smokeless tobacco (Modify Current HOD Policy)</u>; and be it further RESOLVED, That our AMA amend Policy H-495.976, "Opposition to Exempting the Addition of Menthol to Cigarettes," by addition and deletion as follows: Our AMA: (1) will continue to support a ban on the use and marketing of menthol in ~~cigarettes~~ <u>all tobacco products</u> as a harmful additive; and (2) encourages and will assist its members to seek state bans on the sale of menthol cigarettes, <u>electronic nicotine delivery devices and other tobacco products</u>. (Modify Current HOD Policy)
K	Res. 919	ATS	Raising Awareness of the Health Impact of Cannabis

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			RESOLVED, That our American Medical Association coordinate with other health organizations to develop medical resources on the known and anticipated impact of cannabis on human health and on methods for counseling and educating patients who use cannabis and cannabinoids (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for stronger public health messaging on the negative effects of cannabis and cannabinoid inhalation and ingestion (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for urgent regulatory changes necessary to fund and perform research related to cannabis and cannabinoids (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for minimum purchasing age for cannabis products of at least 21 years old (Directive to Take Action); and be it further RESOLVED, That our AMA continue to use the term “cannabis” in our policies when referencing cannabis plants, and “cannabis derivatives” or “cannabinoids” when referencing their natural chemical derivatives, but will include the term “marijuana” in physician and public education messaging and materials to improve health literacy (Directive to Take Action); and be it further RESOLVED, That our AMA amend policy H-95.924, “Cannabis Legalization for Recreational Use,” by addition and deletion to read as follows: Cannabis Legalization for Recreational Use H-95.924 Our AMA: (1) ~~believes~~ warns that cannabis and cannabinoids can be a threat to health when inhaled or ingested; (2) advocates that cannabis and cannabinoids are ~~is a dangerous drug and as such is~~ a serious public health concern; (~~2~~3) ~~believes that~~ warns against the legalized use and sale of cannabis and cannabinoids for recreational ~~use should not be legalized~~ purposes, due to their negative impact on human health; (~~3~~4) ~~discourages~~ warns against cannabis and cannabinoid use for recreational purposes, especially by ~~persons vulnerable to the drug's effects and in high-risk populations such as youth,~~ children and young adults, pregnant women, and women who are breastfeeding; (~~4~~5) ~~believes~~ strongly advocates that states that have already legalized cannabis (for medical or recreational use or both) should be required to take steps to regulate ~~the product~~ cannabis and cannabinoids effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (~~5~~6) strongly encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis and cannabinoid use; and (~~6~~7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis or cannabinoids for personal use. (Modify Current HOD Policy)

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
K	Res. 920	AAPHP	Maintaining Public Health Focus on Leading Causes of Nicotine-Related Death RESOLVED, That in public statements on nicotine issues, and in discussions with government officials, our AMA seek every reasonable opportunity to remind the American public about: (1) the massive ongoing death toll from combustible cigarettes; (2) the large and solidly demonstrated death toll from environmental tobacco smoke; and (3) the ongoing need for every smoker to find the best possible way to achieve and maintain abstinence from combustible cigarettes. (Directive to Take Action)
K	Res. 921	Madejski	Vaping in New York State and Nationally RESOLVED, That our American Medical Association cooperate with the Medical Society of the State of New York (MSSNY) to express our gratitude to New York Governor Andrew Cuomo and Commissioner of the Department of Health Howard Zucker, MD for their prompt action to protect patients by banning the sale of flavored e cigarettes (Directive to Take Action); and be it further RESOLVED, That our AMA cooperate with MSSNY to express our gratitude to Governor Cuomo and Health Commissioner Zucker for their advice to consumers to avoid vaporization of medical marijuana available under the New York State medical marijuana program (Directive to Take Action); and be it further RESOLVED, That our AMA cooperate with MSSNY to recommend to Governor Cuomo, Commissioner Zucker, and New York State Legislators, and in conjunction with other State Medical Societies, other State Executives, Health Commissioners and Legislatures to take further action to protect consumers from exposure to vaporized products with a moratorium on dispensing of vaporized products to new certificate holders for medical marijuana until data on the long term safety of vaporized marijuana is available (Directive to Take Action); and be it further RESOLVED, That our AMA cooperate with MSSNY to recommend that state and federal representatives work to reschedule marijuana and its' component substances to Schedule II controlled substance to reduce barriers to further study on the efficacy and harms of various marijuana products. (Directive to Take Action)
K	Res. 922	Michigan	Understanding the Effects of PFAS on Human Health RESOLVED, That our American Medical Association advocate for continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for states to minimally follow guidelines regarding levels of perfluoroalkyl and polyfluoroalkyl chemicals recommended by the Centers for Disease Control and Prevention and the Environmental Protection Agency. (Directive to Take Action)
K	Res. 923	Michigan	Support Availability of Public Transit Systems

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			RESOLVED, That our American Medical Association amend current policy H-135.939, “Green Initiatives and the Health Care Community,” by addition and deletion as follows: Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; ~~and~~ (5) the establishment, expansion, and continued maintenance of affordable, reliable public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities (New HOD Policy); and be it further RESOLVED, That our AMA amend current policy H-425.993, “Health Promotion and Disease Prevention,” by addition and deletion as follows: The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; ~~and~~ (5) advocates that health be considered one of the goals in transportation planning and policy development including but not limited to the establishment, expansion, and continued maintenance of affordable, reliable public transportation; and (6) strongly emphasizes the important opportunity for savings in health care expenditures through prevention. (Modify Current HOD Policy)
K	Res. 924	Michigan	Update Scheduled Medication Classification RESOLVED, That our American Medical Association amend current policy D-120.979, “DEA Regulations and the Ability of Physicians to Prescribe Controlled Medication Rationally, Safely, and Without Undue Threat of Prosecution,” by addition as follows: Our AMA supports ongoing constructive dialogue between the DEA and clinicians, including physicians, regarding: (1) a proper balance between the needs of patients for treatment and the needs of the government to provide oversight and regulation to minimize risks to public health and safety; and (2) potential changes to the controlled

Cmte*	Item	Sponsor†	Title / Recommendations or Resolves
			substances schedules to make it easier to differentiate opioid containing controlled substances from non-opioid controlled substances within each schedule. (Modify Current HOD Policy)

Reference committees of the House of Delegates
Con = Reference Committee on Amendments to Constitution and Bylaws
B = Reference Committee B
C = Reference Committee C

F = Reference Committee F
J = Reference Committee G
K = Reference Committee K

AMA councils
CCB = Constitution and Bylaws
CEJA = Ethical and Judicial Affairs
CLRPD = Long Range Planning and Development
CME = Medical Education
CMS = Medical Service
CSAPH = Science and Public Health

† Only the first organization is listed for those resolutions sponsored by multiple entities

** Resolution recommended against consideration at I-19.

INTERNATIONAL MEDICAL GRADUATES SECTION
PRELIMINARY TIMELINE FOR RESOLUTIONS/ REPORTS REVIEW
2020 ANNUAL MEETING

AMA-IMGS: June 6-8, 2020
AMA-HOD Meetings: June 6-10, 2020

Hyatt Regency Chicago

	DUE DATES
Deadline for A-20 Resolutions	April 1
Virtual Congress (review reports/resolutions and provide online testimony)	April 6-10
Virtual Congress Conference Call	Monday, April 13 (8 pm CST)
Deadline to receive I-20 resolutions for discussion at Annual Meeting	May 1
Congress Ratification of Reports and Resolutions	April 20-24
House of Delegates Deadline for Handbook Addendum deadline:	May 1 May 8

INTERNATIONAL MEDICAL GRADUATES SECTION
2019 ANNUAL MEETING SUMMARY OF ACTIONS
HYATT REGENCY - CHICAGO

IMG SECTION (IMGS) AUTHORED RESOLUTIONS

I. Reference Committee B

A. Resolution 509 – Addressing Depression to Prevent Suicide Epidemic

Resolution 509 asked: 1) that our American Medical Association collaborate with the Centers for Disease Control, the National Institute of Health and other stakeholders to increase public awareness about symptoms, early signs, preventive and readily available therapeutic measures including antidepressants to address depression and suicide; (Directive to Take Action) and

2) that our AMA work with the Centers for Disease Control, the National Institute of Health and encourage other specialty and state medical societies to work with their members to address the epidemic of depression and anxiety disorder and help to prevent death by suicide by promoting services to screen, diagnose and treat depression. (Directive to Take Action)

HOD Action: Reaffirmation of AMA policy in lieu of Resolution 509.

II. Reference Committee C

A. Resolution 311 – Grandfathering Qualified Applicants Practicing in U.S. Institutions with Restricted Medical Licensure

Resolution 311 asked that the American Medical Association work with the Federation of State Medical Boards, the Organized Medical Staff Section and other stakeholders to advocate for state medical boards to support the licensure to practice medicine by physicians who have demonstrated they possess the educational background and technical skills and who are practicing in the U.S. Healthcare system. (Directive to Take Action)

HOD Action: Resolution 311 referred.

B. Resolution 312 – Unmatched Medical Graduates to Address the Shortage of Primary Care Physicians

Resolution 312 asked: 1) that our American Medical Association advocate for the state medical boards to accept medical graduates who have passed USMLE Steps 1 and 2 as their criterion for limited license, thus using the existing physician workforce of trained and certified physicians in the primary care field and allowing them to get some credit towards their residency training as is being contemplated in Utah. (Directive to Take Action); and

2) that our AMA work with regulatory, licensing, medical, and educational entities dealing with physician workforce issues: the American Board of Medical Specialties, the Association of American Medical Colleges (AAMC), the Association for Hospital Medical Education, Accreditation Council for Graduate Medical Education (ACGME), the Federation of State Medical Boards, and the National Medical Association work together to integrate unmatched physicians in the primary care workforce in order to address the projected physician shortage. (Directive to Take Action)

HOD Action: Resolution 312 withdrawn.

III. HOUSE OF DELEGATES REPORTS/RESOLUTIONS

A. Board of Trustees Report 25 – All Payer Graduate Medical Education Funding
Board of Trustees Report 25 recommended that our AMA amend Policy D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," with the addition of a new clause to read as follows, and that the remainder of the report be filed:

1. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs. (Modify Current HOD Policy)

2. That our AMA rescind section 33 of Policy D-305.967, which directed the AMA to conduct the study herein. (Rescind AMA Policy)

HOD Action: Board of Trustees Report 25 adopted.

B. CME Report 1 – Council on Medical Education Sunset Review of 2009 House Policies

CME Report 1 recommended that the House of Delegates policies listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed..

HOD Action: Council on Medical Education Report 1 adopted and the remainder of the report filed.

C. CME Report 3 - Standardizing the Residency Match System and Timeline

CME Report 3 asked:1) That our AMA encourage appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions; 2). That our AMA work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) to create local PGY-1 positions that will enable coordinated applications and interviews for medical students; 3) That our AMA encourage the NRMP to design a process that will allow competency-based student graduation and off-cycle entry into residency programs; and 4). That our AMA encourage the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

HOD Action: Council on Medical Education Report 3 adopted as amended.

Recommendation 2 amended by addition:

2. That our AMA work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students;

Recommendation 3 deleted:

3. ~~That our AMA encourage the NRMP to design a process that will allow competency-based student graduation and off-cycle entry into residency programs; and~~

D. CME Report 4 – Augmented Intelligence in Medical Education

CME Report asked: 1. That our AMA encourage accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards; 2. That our AMA encourage medical specialty societies and boards to consider production of specialty-specific educational modules related to AI; 3. That our AMA encourage research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes; 4. That our AMA encourage institutions and programs to be deliberative in the determination of when AI assisted technologies should be taught, including consideration of established evidence based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules; 5. That our AMA encourage stakeholders to provide educational materials to help learners guard against inadvertent dissemination of

bias that may be inherent in AI systems; 6. That our AMA encourage enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients; 7. That our AMA encourage institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and 8. That Policy D-295.328, "Promoting Physician Lifelong Learning," be reaffirmed.

HOD Action: CME Report 4 adopted as amended.

E. CME Report 5 – Accelerating Change in Medical Education Consortium Outcomes

CME Report 5 provided a detailed description of the activities and outcomes of the ACE initiative. Impacts on students, faculty members, member institutions, health systems, the general medical education community, patients, and the reputation of the AMA are described. Future directions to advance our AMA's role as a catalyst for medical education innovation were also outlined in this report.

HOD Action: CME Report 5 filed.

F. CME Report 6 – Study of Medical Student, Resident and Physician Suicide (considered with Resolution 307 – Mental Health Services for Medical Students and Resolution 310 – Mental Health Care for Medical Students

CME Report 6 asked: 1. That our AMA explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; 2. That our AMA monitor progress by the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; 3. That our AMA supports the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma free behavioral health services; 4. That our AMA collaborate with other stakeholders to study the incidence of suicide among physicians, residents, and medical students; and 5. That Policy D-345.984, "Study of Medical Student, Resident, and Physician Suicide," be rescinded, as having been fulfilled by this report and through requests for action by the Liaison Committee on Medical Education and ACGME.

HOD Action: **Council on Medical Education Report 6 adopted as amended in lieu of Resolutions 307 and 310 and the remainder of the report filed.**

Recommendation 1: That our American Medical Association (AMA) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long term studies. (Directive to Take Action)

Recommendation 3: That our AMA supports the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free behavioral mental health and substance use disorder services. (Directive to Take Action)

Recommendation 4: That our AMA collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and addiction, and suicide among physicians, residents, and medical students. (Directive to Take Action)

G. CLRPD Report 1 – Demographic Characteristics of the House of Delegates and AMA Leadership

CLRPD Report 1 was an informational report that addressed the demographic characteristics of members in the House of Delegates.

HOD Action: CLRPD Report 1 filed.

H. Resolution 009 – References to Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment

Resolution 009 asked that our AMA undertake a study to identify all discrimination and harassment references in AMA policies and the code of ethics, noting when the language is consistent and when it is not, and research language and terms used by other national organizations and the federal government in their policies on discrimination and harassment. The resolution asks that the preliminary study results be presented to the Minority Affairs Section, the Women's Physician Section, and the Advisory Committee on LGBTQ Issues to reach consensus on optimal language to protect vulnerable populations including racial and ethnic minorities, sexual and gender minorities, and women, from discrimination and harassment. The resolution asks for a report with the study results and recommendations within 18 months.

HOD Action: **Resolution 009 adopted.**

I. Resolution 233 – GME Cap Flexibility

Resolution 233 asked: 1) the AMA to advocate for the Centers for Medicare and Medicaid Services (CMS) to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to primary care residencies (Directive to Take Action); and 2) that the AMA advocate for CMS to provide funding to hospitals and/or universities prior to the arrival of any residents, removing the clause where "Medicare funding does not begin until the first resident is 'on-duty' at the hospital." (Directive to Take Action)

HOD Action: **Policy D-305.967 adopted as amended in lieu of Resolution 233.**

Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

Our AMA will advocate to the Centers for Medicare & Medicaid Services ~~for flexibility beyond the current maximum of five years for the Medicare graduate medical education cap-setting deadline for new residency programs in underserved areas and/or economically depressed a~~areas.to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

J. Resolution 303 – Graduate Medical Education and the Corporate Practice of Medicine

Resolution 303 asked: 1) That the AMA recognize and support that the environment for education of residents and fellows must be free of the conflict of interest created between corporate-owned lay entities' fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs; and 2) That our AMA support that the Accreditation Council for Graduate Medical Education require that graduate medical education programs must be established in compliance with all state laws, including prohibitions on the corporate practice of medicine, as a condition of accreditation.

HOD Action: **Resolution 303 adopted as amended.**

RESOLVED, That our American Medical Association recognize and support that the environment for education of residents and fellows must be free of the conflict of interest created between ~~corporate-owned lay entities' a~~ training site's fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs (New HOD Policy); and be it further

RESOLVED, That our AMA ~~support~~ encourage ~~that~~ the Accreditation Council for Graduate Medical Education (ACGME) to update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources. ~~require that graduate medical education programs must be established in compliance with all state laws, including prohibitions on the corporate practice of medicine, as a condition of accreditation~~. (New HOD Policy)

RESOLVED, That our AMA study issues, including waiver of due process requirements, created by corporate-owned lay entity control of graduate medical education sites. (Directive to Take Action)

K. Resolution 314 – Evaluation of Changes to Residency and Fellowship Application and Matching Processes

Resolution 314 asked: 1).That our AMA support proposed changes to residency and fellowship application requirements only when (a) those changes have been evaluated by working groups which have students and residents as representatives; (b) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate; (c) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds; and (d) the costs to medical students and residents are mitigated; 2). That our AMA oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met; and 3). That our AMA continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

HOD Action: **Resolution 314 adopted as amended.**

RESOLVED,That our American Medical Association ~~support~~ oppose ~~proposed~~ changes to residency and fellowship application requirements ~~only when~~ unless (a) those changes have been evaluated by working groups which have students and residents as representatives; (b) there are data which ~~d~~demonstrates that the proposed application components contribute to an accurate representation of the candidate; (c) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of ~~implicit~~ bias that affects medical students and residents from underrepresented minority backgrounds; and (d) the costs to medical students and residents are mitigated (New HOD Policy): and be it further

~~RESOLVED, That our AMA oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met (New HOD Policy); and be it further~~

L. Resolution 317 – A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities

Resolution 317 asked the AMA to work with relevant stakeholders to study available data on medical trainees with disabilities and consider revision of technical standards for medical education programs.

HOD Action: **Resolution 317 adopted as amended**.

RESOLVED, That our AMA work with relevant stakeholders to study available data on medical graduates with disabilities and challenges to employment after training. (Directive to Take Action)

M. Resolution 318 – Rural Health Physician Workforce Disparities

Resolution 318 asked the AMA to undertake a study of issues regarding rural physician workforce shortages, including federal payment policy issues, and other causes and potential remedies to alleviate rural physician workforce shortages.

HOD Action: **Resolution 318 adopted as amended.**

N. Resolution 613 – Language Proficiency Data of Physicians in the AMA Masterfile *(Minority Affairs Section)*

Resolution 613 asked our AMA to initiate collection of self-reported physician language proficiency data in the Masterfile by asking physicians with the validated six-point adapted ILR-scale to indicate their level of proficiency for each language besides English in the healthcare settings.

HOD Action: **Resolution 613 referred.**

O. Resolution 614 – Racial and Ethnic Identity Demographic Collection by the AMA

Resolution 614 asked the AMA to develop a plan, with input from the Minority Affairs Section and the Chief Health Equity Officer, to consistently include racial and ethnic minority demographic information for physicians and medical students.

HOD Action: **Resolution 614 adopted as amended.**

Education Materials

Schedule of education sessions
Speaker biographies

Addressing the challenge of equitable drug pricing in the era of precision medicine

2019 AMA Interim Meeting

5:15 p.m. – 6 p.m. | Saturday, November 16 | Harbor B
Manchester Grand Hyatt | San Diego, California
.75 AMA PRA Category 1 Credits

Program Description

The crisis of rising drug costs have resulted in patients making an adverse decision of not purchasing their medication. This session will discuss the need to have an International Price Index in order to control the disparities in drug pricing for patients.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

Deadline for claiming CME credit is **December 31, 2019**. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

Back to the Basics:

The Fundamentals of

Extraordinary Leadership

2019 AMA Interim Meeting

2:30 p.m. – 3:30 p.m. | Sunday, November 17 | Coronado D
Manchester Grand Hyatt | San Diego, California
1.0 AMA PRA Category 1 Credits

Program Description

Provide executive coaching to develop the participants' attributes of leadership. Make recommendations for the weaknesses and strengths derived from participant management styles to improve their leadership skills.

To claim your credit, visit the AMA Ed Hub™—your center for personalized learning from sources you trust. amaedhub.com/pages/ama-interim-meeting-2019

Deadline for claiming CME credit is **December 31, 2019**. For questions, contact us at (800) 337-1599 or HODmeetingsupport@ama-assn.org

Speakers' Letter

2019 Interim Meeting of the AMA House of Delegates
November 16–19, 2019
Manchester Grand Hyatt – San Diego, California

Ladies and Gentlemen:

The following information is provided to aid your planning for the upcoming Interim Meeting in San Diego. **All attendees should be aware of the requirement to accept our AMA's policy on conduct at AMA meetings, and the procedures for delegates and alternate delegates are noted on page 2.** Also noted on that page is information on enhanced security for I-19. The online member forums are again available for this meeting, and we encourage you to promote the forums to your colleagues (see page 4 for details). The forums allow our membership to weigh in on policy matters, and use of the forums helps reference committees anticipate the issues that are likely to garner the most attention or concern.

Please call 312.464.4463, email hod@ama-assn.org or visit ama-assn.org/interim-meeting if you have questions regarding any of the following items or questions on American Medical Association policy. Watch the Interim Meeting website for updates to this *Speakers' Letter*.

Bruce A. Scott, MD, Speaker
Lisa Bohman Egbert, MD, Vice Speaker

House of Delegates schedule

The 2019 Interim Meeting of the AMA House of Delegates (HOD) will meet Nov. 16–19 at the Manchester Grand Hyatt in San Diego, California. The HOD will convene at 2 p.m. Saturday, Nov. 16 in the Seaport Ballroom. The Opening Session will conclude no later than 6 p.m. On Sunday, Nov. 17, the AMA-HOD will be in session from 8 to 8:30 a.m. to receive items of business, consider acceptance of late resolutions, and extract informational reports and items from the reaffirmation consent calendar. The following reference committees will convene open hearings from 8:30 a.m. to noon Sunday (room assignments subject to change):

Reference Committee on Amendments to Constitution & Bylaws	Grand Hall C
Reference Committee B (legislation)	Harbor Ballroom G–I
Reference Committee C (medical education)	Harbor Ballroom A–C
Reference Committee F (AMA governance and finance)	Seaport Ballroom
Reference Committee J (medical service, medical practice, insurance)	Harbor Ballroom D–F
Reference Committee K (science and public health)	Grand Hall D

Your Speakers believe that the likely number and nature of the medical education-related items warrants placing that business in a separate reference committee. This accords with past practice, as the business determines reference committee assignments.

The AMA-HOD will reconvene at 2 p.m. Monday, Nov. 18, and 8:30 a.m. Tuesday, Nov. 19 and will adjourn by noon on Tuesday. Your Speakers ask delegates to schedule departures no earlier than Tuesday afternoon so that they can fully consider the business debated that day.

Meeting details and reminders

Special Accommodations
Delegates and alternate delegates may request special accommodations (e.g., an assistive listening device) by contacting the Office of House of Delegates Affairs. Please call 312.464.4344 or send an email to hod@ama-assn.org so that arrangements can be made.

We have inquired about the availability of family and gender-neutral restrooms. California's Health and Safety Code specifies requirements for family / gender neutral restrooms that the Manchester Grand Hyatt's facilities do not satisfy. The Marriott does have one family restroom.

Handbook distribution
The initial Handbook will be posted on the Interim Meeting website by October 18. It will be posted as a single large document as well as in a series of smaller documents, collated by reference committee. The Addendum will be posted about October 25. When it is posted, the original Handbook and Addendum will be available separately along with a combined document that interleaves the Addendum with the Handbook. Like all other meeting materials, the Handbook will be posted at ama-assn.org/interim-meeting. An abridged Handbook containing only the recommendations from reports and the resolve clauses from resolutions will also be available as a Word document.

Registration
Registration for the AMA-HOD will be in the Palm Foyer, Seaport Tower, Second level. For security purposes, all attendees will be required to provide photo identification at the AMA registration desk to receive their credentials and other materials. Registration will be open from 10:30 a.m. to 7 p.m. Thursday, Nov. 14 and open at 7 a.m. from Friday through Tuesday.

Delegates and alternate delegates should check with their sponsoring society to ensure that their names have been submitted to the Office of House of Delegates Affairs prior to this meeting. AMA bylaws require that all delegates and alternate delegates be properly credentialed before *each* AMA-HOD meeting. Individuals whose credentials have not been confirmed prior to the Interim Meeting will have to be accompanied to the AMA registration desk by an officer of their society to register.

Delegates and alternate delegates for whom we have full contact information will find attached to printed copies of this *Speakers' Letter* a form that will implement Policy G-600.032, "Delegate Credentialing and Expectations for Behavior," which the House adopted in June. **The form must be completed, signed and turned in to AMA registration staff at the Manchester Grand Hyatt to obtain credentials.** The form also allows delegates and alternate delegates to update the information that appears in the Pictorial Directory as well as to provide emergency contact information. Blank forms will be available in San Diego, but we encourage you to complete the form in advance to facilitate your onsite registration. Readers of the online *Speakers' Letter* should print the form, complete it and bring it to San Diego.

Individuals other than delegates and alternate delegates who attend the Interim Meeting should register online by visiting the interim meeting website. All attendees, including guests, are required to acknowledge and accept Policy H-140.837, "Policy on Conduct at AMA Meetings and Events." Those not registered in advance will have to complete their acknowledgement onsite before receiving a badge. A badge will be required to attend all functions.

Meeting security
Attendees will see increased security at the Interim Meeting, starting with name badges. Not only are the badges being changed, but those not wearing their badges in and around the House may expect to be asked to display their badge. While your badge will be needed inside the meeting venue, don't forget to remove it when you leave the facility. Additional security enhancements will also be apparent in and around the meeting venue.

Recording of AMA-HOD meetings
AMA meetings may be recorded by audiotape, videotape or otherwise, for use by the AMA. Participation in or attendance at a meeting shall be deemed to confirm the participant's consent to recording and to the AMA's use of such recording.

Code of conduct
Referenced above (page 2) is our AMA's code of conduct, which was designed to ensure a professional and welcoming environment for all attendees at AMA-sponsored meetings. Importantly, everyone should feel safe and able to participate without fear of unwelcome conduct, whether in face-to-face contacts or electronic communications. Attendees should declare conflicts of interest and conduct themselves in a manner that is attune to the highest ideals of the profession. The policy can be accessed at ama-assn.org/codeofconduct. Harassment and conflicts of interest are serious, and House policy provides for reporting and dealing with both matters.

Our standing rules, which are ratified in the opening session, commit each of us to be courteous, respectful and collegial in the conduct of HOD business. Instances of unwelcome or inappropriate behavior should be brought to the attention of your Speakers or the conduct liaison, and everyone has the personal responsibility, while engaging with others, to consider how others will interpret their actions and words.

Meeting attire
Your Speakers have determined that business casual attire is appropriate for the Interim Meeting, except when individuals are on the dais, at which time business attire is requested. This would include the presentation of reference committee reports or any other report given from the dais.

Childcare services
Childcare will be available from 7 a.m. to 7 p.m. Thursday, Nov. 14 through Monday, Nov. 18 and from 7 a.m. to noon on Tuesday, Nov. 19. Registration is available through the vendor or the meeting website. Reservations are required to ensure space, but walk-ins will be accepted when possible. Fees are somewhat lower than they have been:

	6 months to 35 months	Age 3 years to 17 years
Half day (7 a.m. to 1 p.m. **or** 1 p.m. to 7 p.m.)	$50	$40
Full day (7 a.m. to 7 p.m.)	$80	$70
Tuesday (7 a.m. to noon)	$45	$40
Hourly rate, 4 hour minimum	$12/hr	$10/hr

There is a $10 non-refundable administrative fee per child. The vendor, Accent on Children, is fully licensed, and caregivers have considerable experience in working with children. Meals are available separately for $15, but meals will not be available for purchase onsite through Accent.

Nursing mothers
A location will be available for nursing mothers who wish to express milk or nurse their infants. Interested mothers should contact the AMA Headquarters Office.

Travel discounts
A discount is available on United Airlines and may be accessed through the meeting website or obtained online at united.com.

- Click on "Advanced search"
- Enter origin, destination, and travel dates
- Enter Offer Code ZGE5912085 in the "Promotions and Certificate" box

When an available flight is selected, the discounted fare will automatically be calculated. The discount is valid for travel 3 days prior to and 3 days after the official meeting dates. A discount may also be obtained by calling United Airlines Meetings at 800.426.1122 and mentioning Z code ZGE5 and Agreement code 912085. A service fee will apply to telephone bookings.

Distribution of non-business items
Material received in the production area of the Headquarters Office at the hotel by 5 p.m. Thursday, Nov. 14, will be collected in a bag and placed on delegates' tables and on chairs before the House opens on Saturday. Thirteen hundred (1300) copies are required for a complete distribution throughout the House. When you arrive in San Diego, we suggest that you check with AMA staff in the production area to ensure that your materials were received. Mailing information to ensure proper delivery was included with the meeting information memo (available online).

Opening Session agenda
The Opening Session will get underway at 2 p.m. Saturday, Nov. 16 in the Seaport Ballroom. Included in the Opening Session will be the presentation of various awards and addresses by AMA President Patrice Harris, MD, and Executive Vice President James Madara, MD. The session will conclude by 6 p.m.

Nomination and election of new public member of the Board of Trustees
As we go to print, the nomination of the new public member of the Board of Trustees is also expected during the Opening Session, with the election taking place either Saturday afternoon or Sunday morning, depending on when the candidate's conflict of interest disclosure is posted to the AMA website.

Although the new public member will be elected in San Diego, the current public member, Kevin Williams, serves until the close of the next Annual Meeting. The early election of his successor is supported in our bylaws and allows the new public member to gain exposure to the Board's operations before taking office.

Meeting app
Our AMA's mobile app will again be available for the Interim Meeting to help attendees connect and network with peers. Use the app during the meeting for comprehensive information about activities and events. As in June the app will allow users to integrate the meeting schedule with their mobile device calendar, create session notes and appointments, and access interactive maps of the hotel, which will provide event locations. Important meeting updates will also be provided through the notification tools in the app.

Users should download the "AMA 2019 Interim Meeting" app from their app store. Search for CrowdCompass AttendeeHub. Once there, search "AMA" and tap on the 2019 AMA Interim Meeting. The app launches about October 28.

Online member forums
As mentioned in the meeting information memo, each reference committee includes an online member forum. The forums can be accessed directly at ama-assn.org/forums/house-delegates or via the meeting website. Items will be added over time, so we suggest that you check back occasionally. Instructions are found on the site. Questions about the forum can be sent to hod@ama-assn.org or to roger.brown@ama-assn.org.

The forums will remain open for commenting up to the opening of the House, but comments posted after Sunday, Nov. 10 are unlikely to be captured in the summary reports that are prepared and posted on the meeting website.

PolicyFinder
The latest edition of PolicyFinder is available at policysearch.ama-assn.org. The current version is complete through the 2019 Annual Meeting.

Proceedings of the 2019 Annual Meeting
The *Proceedings* of the House of Delegates for the 2019 Annual Meeting (A-19) have been posted on the AMA website. Approval of the minutes from A-19 is an action item at the Sunday morning session of the AMA-HOD. Corrections should be sent to hod@ama-assn.org.

Conflict-of-interest policy
Sponsors of resolutions are reminded that the AMA-HOD has established policy (G-600.060) calling on delegates introducing an item of business for consideration by the AMA-HOD to declare any commercial or financial conflict of interest at the time the resolution is submitted and that any such conflict of interest be included with the resolution.

Your Speakers have determined that this policy also applies to resolutions introduced by delegations. The sponsoring delegation must disclose the identity of any delegate or alternate delegate who has a commercial or financial interest with respect to matters addressed in the resolution. If a conflict is disclosed, the notation on the resolution will not contain an individual delegate's name, but will state in substance that, "In accordance with House policy regarding disclosure of conflicts of interest, the delegation has notified the Speaker that one or more delegates has a commercial or financial conflict of interest with respect to the matters addressed in this resolution." For resolutions already submitted, please notify the AMA Office of House of Delegates Affairs. A revised resolution containing the conflict-of-interest statement will be distributed.

HOD Reference Manual: Procedures, Policies and Practices
The HOD Reference Manual describes House procedures. Available online, it may be accessed through the meeting website. The manual may be especially helpful to new delegates, but it is also a good reference for experienced delegates, Federation staff and other meeting participants. The House will be asked to adopt the updated reference manual as the official method of procedure in handling and conducting the business as part of the rules report at the opening session.

Announcements for 2020 elections
Individuals who intend to seek election at the 2020 Annual Meeting are reminded that printed announcements may not be distributed in the meeting venue. Announcements provided to us by noon, Sunday, Nov. 17 will be projected on the last day of the meeting. An electronic announcement should be submitted to Roger Brown (roger.brown@ama-assn.org) in the Speakers' Office; the preferred format is JPG, but a PDF or PowerPoint slide (16:9 format) is also acceptable. Submissions will be maintained in confidence until posted. Announcements will be posted online after the meeting.

Meetings and caucuses

OSMAP
The Organization of State Medical Association Presidents (OSMAP) will hold its semi-annual membership meeting and general session from 2 to 5 p.m. Friday, Nov. 15 in Harbor Ballroom A-B. All state medical association presidents, presidents-elect, past presidents and executive directors are welcome and encouraged to attend. An agenda and related meeting materials will be posted on the OSMAP web site (osmapandtheforum.org) prior to the meeting.

If you have any topics you would like submitted for the agenda, please contact Brian O. Foy, OSMAP Executive Director, at bfoy11@yahoo.com. Immediately following the general session, OSMAP will host a reception in Harbor Ballroom D-F. All OSMAP members and their invited guests are welcome to attend.

Surgical Caucus Handbook review
The Surgical Caucus of the AMA will meet from 7 to 9:30 a.m. Saturday, Nov. 16 in Coronado E for a combined business meeting/handbook review session; breakfast will be available at 6:45 a.m. Specialties in the Caucus are encouraged to send at least one representative to this meeting.

Rural Health Caucus
Residents of rural areas have been shown to be generally sicker, poorer, and older than their counterparts in urban areas. Recent research shows that women do not have access to obstetric care in 54% of rural counties. These issues are further compounded by health care workforce shortages and decreased resource availability.

The challenges that rural patients and those who care for them face result in unique perspectives on the practice of medicine.

All AMA meeting attendees, including delegates and alternate delegates, representatives of state or specialty societies, medical students, residents, section leaders, AMA staff, and Board members are invited to attend the Rural Medicine Caucus policy discussion at 1 p.m. Sunday, Nov. 17 in Regatta. Attendees will enjoy networking with colleagues, sharing ideas on how the AMA might better serve rural physicians and patients, and discussing any resolutions that attendees feel are applicable to practice in rural or other low-resource settings. Please contact Jordan Warchol, MD, at JordanWarcholMD@gmail.com for more information.

Election task force open forum
In lieu of our usual speaker-to-speaker meeting on Sunday afternoon, the election task force that was approved in June will hold an open forum to hear suggestions and discuss options for improving our election processes. The task force will submit an initial report in San Diego as called for by Policy G-610.031. This report will provide a framework for the discussion but will not include their final recommendations. Comments or suggestions may be sent to hod@ama-assn.org for consideration by the task force.

The forum will be styled like and follow the reference committee hearings. It will begin at 1 p.m. and run as long as necessary in Grand Hall D.

Private Practice Physician's Congress
The Private Practice Physician Congress will meet at 11:30 a.m. Monday, Nov. 18 in Harbor Ballroom A-B. All AMA members interested in the private practice of medicine, including young physicians, residents, fellows and medical students, are invited to join the meeting. The group includes primary care and specialty care physicians.

For questions or comments please contact Zuhdi Jasser, MD, Chair, at zuhdi@jasserim.com or 602.721.7186; Tim McAvoy, MD, Vice-chair, at timothymcavoy@yahoo.com or 414.573.0751; or Barb Hummel, MD, Secretary, at hummelb@ameritech.net or 414.690.6352.

Educational programming

Several education programs will be offered during the Interim Meeting. All members are welcome to attend any of the education sessions listed below, many of which are sponsored by the sections and special groups. These sessions will be offered between Thursday, Nov. 14 and Monday, Nov. 18. Many sessions will be sponsored by the AMA sections, although details for many remain to be worked out.

Education sessions designated by the AMA for CME credit are indicated by an asterisk (*).

> The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
> The American Medical Association designates each live activity for the maximum number of *AMA PRA Category 1 Credits*™ reflected with each session. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The deadline to claim credit for sessions certified by the AMA is December 31, 2019. To claim credit, access the session on the meeting mobile app or visit the AMA Ed Hub™ at edhub.ama-assn.org. For help in claiming credit or printing certificates, visit the AMA Ed Hub booth. You may also contact the AMA Unified Service Center at 800.262.3211 for assistance.

Sessions certified for credit by other CME providers are indicated with a dagger (†), but those sessions are not available via the AMA Ed Hub.

Sessions that will be held at the Marriott are so noted; all other sessions are at the Manchester Grand Hyatt.

You thought you only had a duty of care to your patients? - Minnesota's Warren v. Dinter decision
1:30–2 p.m. Thursday, Nov. 14, Marina D (Marriott)
Hosted by the AMA Organized Medical Staff Section

Managing gender bias in medical careers
8–8:45 a.m. Friday, Nov. 15, La Costa (Marriott)
Hosted by the AMA Medical Student Section

Adverse childhood experiences and trauma informed care for migrant populations and displaced peoples
8:30–9:15 a.m. Friday, Nov. 15, Coronado (Marriott)
Hosted by the AMA Medical Student Section

No street left behind: How integrated systems affect social determinants of health
8:30 a.m.–noon Friday, Nov. 15, Marina E (Marriott)
Hosted by the AMA Integrated Physician Practice Section

La Frontera—The unknown frontier of women's health care at the US-Mexico border
9–9:45 a.m. Friday, Nov. 15, La Costa (Marriott)
Hosted by the AMA Medical Student Section

Peer review survival kit: Is your peer review process safe?
9:15–10:15 a.m. Friday, Nov. 15, Marina D (Marriott)
Hosted by the AMA Organized Medical Staff Section

Family detention in US immigration: The interface of medical ethics and advocacy
Noon–1:15 p.m. Friday, Nov. 15, Marina F (Marriott)
Hosted by the AMA Young Physicians Section

The AMA policymaking lifecycle: Turing ideas into policy and then into solutions!
12:30–1:15 p.m. Friday, Nov. 15, Marina D (Marriott)
Hosted by the AMA Organized Medical Staff Section

Professionalism on social media, and its uses in networking, advocacy, and professional development
1–1:45 p.m. Friday, Nov. 15, La Costa (Marriott)
Hosted by the AMA Medical Student Section

Employer-driven innovations: Reshaping health care delivery
1–2:30 p.m. Friday, Nov. 15, Marina E (Marriott)
Hosted by the AMA Integrated Physician Practice Section

I am human: A look at shortcomings in the United States prison health care system
1:30–2:15 p.m. Friday, Nov. 15, Coronado (Marriott)
Hosted by the AMA Medical Student Section

The credentialing, privileging, and enrollment processes: How what you don't know can hurt you!
1:30–2:30 p.m. Friday, Nov. 15, Marina D (Marriott)
Hosted by the AMA Organized Medical Staff Section

The promise of Project ECHO as an educational paradigm
1:45–2:45 p.m. Friday, Nov. 15, Grand Hall D
Hosted by the AMA Academic Physicians Section

Seeking mental health care as physicians and future physicians
2–3 p.m. Friday, Nov. 15, Marina G (Marriott)
Hosted by the AMA Medical Student Section

Structural violence—Understanding the bias against patients with a history of substance abuse
2:30–3:15 p.m. Friday, Nov. 15, Coronado (Marriott)
Hosted by the AMA Medical Student Section

Demystifying employment contracts
2:45–3:45 p.m. Friday, Nov. 15, Marina D (Marriott)
Hosted by the AMA Organized Medical Staff Section

Cultural humility and implicit bias: Moving toward equitable health care
3–3:45 p.m. Friday, Nov. 15, La Costa (Marriott)
Hosted by the AMA Medical Student Section

Recruiting, retaining, retraining, and rewarding community physicians
3–4 p.m. Friday, Nov. 15, Grand Hall D
Co-hosted by AMA Academic Physicians Section and the AMA Senior Physicians Section

Unraveling the mysteries of surprise billing
3:30–4:15 p.m. Friday, Nov. 15, Coronado (Marriott)
Hosted by the AMA Medical Student Section

Healthcare think tank: Members Moving Medicine
4–5 p.m. Friday, Nov. 15, La Costa (Marriott)
Hosted by the AMA Medical Student Section

US health care reform—Diving into economic, physician, and patient aspects of proposed health care
8–8:45 a.m. Saturday, Nov. 16, La Costa (Marriott)
Hosted by the AMA Medical Student Section

Developing sustainable global health projects in the age of voluntourism
8:30–9:15 a.m. Saturday, Nov. 16, Coronado (Marriott)
Hosted by the AMA Medical Student Section

Amplify your voice: How physicians can shape health policy
9–9:45 a.m. Saturday, Nov. 16, Harbor Ballroom G-H
Hosted by all AMA Sections and Advisory Committee

Identifying clinical problems and driving needs-oriented innovation in medicine
9–9:45 a.m. Saturday, Nov. 16, La Costa (Marriott)
Hosted by the AMA Medical Student Section

Using cost-effectiveness to determine coverage priorities
9:30–10:15 a.m. Saturday, Nov. 16, Coronado (Marriott)
Hosted by the AMA Medical Student Section

The new MOC: Continuing board certification
9:45–11 a.m. Saturday, Nov. 16, Grand Hall D
Co-hosted by the AMA Academic Physicians Section, the AMA Young Physicians Section, and the AMA Council on Medical Education

Telemedicine and mobile apps—accessing birth control without stepping foot in a clinic
10–10:45 a.m. Saturday, Nov. 16, La Costa (Marriott)
Hosted by the AMA Medical Student Section

The impact of vision and hearing loss in the senior population—Why seeing and hearing are believing
Noon–1:30 p.m. Saturday, Nov. 16, Grand Hall C
Hosted by the AMA Senior Physicians Section

Fair market pricing for prescription drugs
5:15–6 p.m. Saturday, Nov. 16, Harbor Ballroom B
Hosted by the AMA International Medical Graduates Section

Investigating gender bias in medical student evaluations
6–6:30 p.m. Saturday, Nov. 16, Harbor Ballroom A
Hosted by the AMA Women Physicians Section

Health Impact of Climate Change - Preparing Your Communities and Practices
1–3:30 p.m. Sunday, Nov. 17, Harbor Ballroom A-B
Hosted by the Forum for Medical Affairs

This program will feature three prominent speakers in the field of climate change and health. Nitin S. Damle, MD, Clinical Associate Professor of Medicine, Alpert Medical School of Brown University, and ACP Delegate, will kick off with "Climate Change and Health: The Greatest Health Threat and Opportunity of the 21st Century." Next, Mona Emily Senay, MD, MPH, Assistant Professor of Medicine, Department of Environmental Medicine and Public Health, Icahn School of Medicine at Mount Sinai (NY), will present "Healthcare Delivery and the Climate Crisis." Following will be Mona Sarfaty, MD, Executive Director, Medical Society Consortium on Climate and Health, Center for Climate Change Communication, who will present "What Physicians Can Do About Climate Change." A panel discussion will follow with Q&A. The program will be moderated by Steven P. Kanig, MD, Forum President.

Attendees will learn about: 1) the science behind the effects of climate change; 2) the seven health effects of climate change; and 3) what physicians can do to prepare for and respond to these new challenges.

All members of the AMA House of Delegates, their spouses and invited guests, and staff are welcome to attend. There is no cost to attend, and pre-registration is not required. For more information regarding The Forum, please go to osmapandtheforum.org.

***Training Physicians in the Art of the Public Forum (**1.5 *AMA PRA Category 1 Credits*™**)**
2–3:30 p.m. Sunday, Nov. 17, City View [32nd floor] (*also offered 8 a.m. Monday*)
Hosted by AMA Enterprise Communications

Whether you're preparing to deliver a keynote presentation at a high-profile medical conference or talking with a reporter from your hometown newspaper, the ability to support your position with clear and concise language and relevant points is paramount. These sessions are designed to help physicians at all levels better prepare for public speaking opportunities and media interviews through skilled and confident communication. Participants will learn best practices for effective communication, including how the AMA trains its leaders to carrying the message of the organization to diverse audiences. Industry leaders and AMA communications staff will share tips and engage participants in role-playing exercises to help them stay on message and effectively connect with diverse audiences about health care issues and policies that are important to physicians, their patients and their practices.

Following these sessions, attendees will have the opportunity to become AMA Ambassadors and further their learning around public engagement. The trainings will be led by Kathy Schaeffer, a strategic

communications expert, in partnership with leaders from the AMA's Enterprise Communications department. Attendees are asked to RSVP ahead of the sessions to tamara.washington@ama-assn.org.

Litigation Center Open Meeting
2–4 p.m. Sunday, Nov. 17, Harbor Ballroom D-F
Hosted by the Litigation Center of the American Medical Association and State Medical Societies

The Litigation Center Open Meeting will feature as its principal presentation a moot court argument based on a recent Minnesota Supreme Court case, which found that an internist could be professionally liable to someone who was not his patient and whom he had never met. A discussion will follow about how this holding could affect individual physician practices.

AMA Ambassador Training Sessions

2–2:45 p.m. Sunday, Nov. 17, America's Cup A-B
Are you new to the AMA Ambassador Program? This onboarding session will allow you to hit the ground running as an AMA Ambassador.

3–4 p.m. Sunday, Nov. 17, America's Cup A-B
Your personal and professional brand is everything! During this session, Dr. Tyeese Gaines of Doctor Ty Media, will share the best practices for physicians and AMA Ambassadors as they build a brand, cultivate followers and create their niche.

3–4 p.m. Sunday, Nov. 17, America's Cup C-D
Being an ambassador on social media is more than just amplifying news, it's also about effectively responding and engaging in conversation. Join us for a breakout session where we'll dig into case studies, both positive and negative, and workshop how best to respond in each scenario.

4–5 p.m. Sunday, Nov. 17, America's Cup A-B
What do you say when colleagues ask, "Why are you an AMA member?" Or when colleagues ask, "what exactly does the AMA do?" In this session, you will hone your Ambassador skills and perfect your elevator pitch. First you will hear from a couple AMA experts and seasoned Ambassadors and then you will practice your elevator pitch as well as provide constructive feedback to others.

4–5 p.m., Sunday, Nov. 17, America's Cup C-D
Whether you're new to the program or simply need a refresher, join us for a deep dive on how to use the AMA's activation hub, Smarp. As an ambassador, consider Smarp your digital "pantry" where you can find content to easily share to your social media channels. Or if you're still feeling unsure about social media in general, stop by during this time to chat with AMA social media staff about any specific questions or concerns you may have.

Back to basics: The fundamentals of extraordinary leadership
2:30–3:30 p.m. Sunday, Nov. 17, Coronado D
Hosted by the AMA International Medical Graduates Section

AMPAC Presents an Insiders "How to" Guide to Running and Winning a Campaign
3–4 p.m. Sunday, Nov. 17, Grand Hall C
Hosted by AMPAC

Have you ever wondered how doctors get elected to public office? Have you considered a run for office yourself? Join us for an in-depth preview of AMPAC's annual "Candidate Workshop" political education program. Led by Eva Pusateri, lead consultant and trainer for the AMPAC Candidate Workshop, in this session you will learn how the intensive two-day Candidate Workshop will prepare you with the tools you need to run a winning political campaign. The program is designed to help you make the leap from the exam room to campaign trail and give you the strategic advantage you will need to make your run for public office.

Changes to Reporting Evaluation and Management Office Visits: How to Prepare for 2021
3–4:30 p.m. Sunday, Nov. 17, Harbor Ballroom G-I
Hosted by the CPT/RUC Workgroup on Evaluation and Management

The Co-Chairs of the CPT/RUC Workgroup on Evaluation and Management (E/M) will describe the new CPT framework for reporting office visits. On Nov. 1, CMS announced that Medicare will implement these changes on January 1, 2021. Physicians will no longer be required to engage in unnecessary and burdensome documentation to report office visits. The new framework will provide physicians with reporting by either total time spent on the date of the visit or the medical decision-making used in the provision of the service. Doctors Peter Hollmann and Barbara Levy will also explain the AMA/Specialty Society RVS Update Committee's recommendations to increase the valuation of office visits.

***Training Physicians in the Art of the Public Forum (**1.5 *AMA PRA Category 1 Credits*™**)**
8–9:30 a.m. Monday, Nov. 18, Grand Hall D (*also offered 2 p.m. Sunday*)
Hosted by AMA Enterprise Communications

Whether you're preparing to deliver a keynote presentation at a high-profile medical conference or talking with a reporter from your hometown newspaper, the ability to support your position with clear and concise language and relevant points is paramount. These sessions are designed to help physicians at all levels better prepare for public speaking opportunities and media interviews through skilled and confident communication. Participants will learn best practices for effective communication, including how the AMA trains its leaders to carrying the message of the organization to diverse audiences. Industry leaders and AMA communications staff will share tips and engage participants in role-playing exercises to help them stay on message and effectively connect with diverse audiences about health care issues and policies that are important to physicians, their patients and their practices.

Following these sessions, attendees will have the opportunity to become AMA Ambassadors and further their learning around public engagement. The trainings will be led by Kathy Schaeffer, a strategic communications expert, in partnership with leaders from the AMA's Enterprise Communications department. Attendees are asked to RSVP ahead of the sessions to tamara.washington@ama-assn.org.

***CEJA Open Forum - Identifying Gaps in the *Code of Medical Ethics* (**1.5 *AMA PRA Category 1 Credits*™**)**
9:30–11 a.m. Monday, Nov. 18, Grand Hall C
Hosted by the Council on Ethical and Judicial Affairs

The Open Forum will be open to all AMA members, interested non-members, other guests, and the press and will have three parts. Parts one and two will consist of participants identifying and discussing potential gaps in the *Code of Medical Ethics* within given chapters. The sections covered will be:

- Chapter 9, Section 7: Interaction with government agencies (35 minutes)
- Chapter 10: Interprofessional Relationships (35 minutes)

Each topic will be introduced by a member of CEJA and followed by a group discussion. Although participants will have time during the session to review the identified content, it may be helpful to review the links above beforehand. This exercise will mimic the types of questions, considerations and framing that go into a CEJA discussion of gaps in the *Code*. Questions for discussion will include:

- Is new ethics guidance needed in this domain? If so, what do you consider the most urgent issue to address?
- How do you see new ethics guidance on the issue fitting into this chapter?
- How do you feel new ethics guidance would
  - Promote patients' interests?
  - Support physicians?
- What implications (if any) do you feel new ethics guidance would have for health care organizations?
- Who do you see as key stakeholders on the issue?

In the third part of the session, attendees are invited to introduce other issues that may warrant attention from CEJA and inclusion in the *Code of Medical Ethics*.

Upon completion of this session, participants will be able to:

- Describe CEJA's approach to identifying topics for new guidance within the *Code of Medical Ethics*
- Explain the nature and scope of CEJA's role in developing ethics policy
- Recognize the challenges of crafting policy in a way which addresses the positions of various stakeholders

President's panel: Physicians' obligation to lead
9:30–11 a.m. Monday, Nov. 18, Harbor Ballroom C
Hosted by our AMA

In this session, you will gain a better understanding of the role of the AMA and its physician members in advocacy and activism in issues related to immigration, women's health, LGBTQ health, gun violence and health equity. AMA's General Counsel will share several AMA litigation examples that demonstrate AMA policies and directives in action. Additionally, a historical perspective on medicine, activism, and socio-political change will be discussed.

The session will be moderated by AMA President Patrice A. Harris, MD, MA, and include a presentation from Brian Vandenberg, JD, AMA's General Counsel, along with a reactor panel made up of AMA Board Chair Jesse Ehrenfeld, MD, MPH; Rodney Hood, MD, past-president, NMA; Aletha Maybank, MD, MPH, AMA's chief health equity officer; and Dalia G. Larios Chavez, MD, a resident at Brigham & Women Hospital.

If you have questions, email J. Mori Johnson at jmori.johnson@ama-assn.org.

Council on Legislation Forum
The Council on Legislation (COL) will hold a one-hour forum from 9 to 10 a.m. Monday, Nov. 18, in Harbor Ballroom DEF.

Hear from the COL's executive committee how our AMA is working to protect the interests of physicians and our patients through its federal and state advocacy efforts. The forum is also intended to provide HOD attendees the opportunity to share with the Council and others their comments on emerging federal and state legislative and regulatory issues impacting patients and the practice of medicine.

†Is there a doctor on board? – Dealing with in-flight emergencies
10–11 a.m. Monday, Nov. 18, Grand Hall D
Hosted by the Surgical Caucus of the AMA

This session will identify the most common in-flight medical emergencies; describe in-flight resources available for responding to a medical emergency; and discuss the legal ramifications of providing care for an in-flight medical emergency.

The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
The American College of Surgeons designates this live activity for a maximum of 1 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Section and Special Group Events

The AMA Section Meetings will be held Nov. 14-16 at the Manchester Grand Hyatt and Marriott Marquis. Visit each section's meeting page for agendas and other meeting documents, and for the most up-to date-information, please refer to the AMA meeting app.

- Academic Physicians Section (APS)
  Nov. 15-16, Manchester Grand Hyatt
- Advisory Committee on LGBTQ Issues (LGBTQ)
  Nov. 15, Manchester Grand Hyatt
- Integrated Physician Practice Section (IPPS)
  Nov. 15, Marriott Marquis
- International Medical Graduates Section (IMGS)
  Nov. 16, Manchester Grand Hyatt
- Medical Student Section (MSS)
  Nov. 14-16, Marriott Marquis
- Minority Affairs Section (MAS)
  Nov. 15-16, Manchester Grand Hyatt
- Organized Medical Staff Section (OMSS)
  Nov. 14-15, Marriott Marquis
- Resident and Fellows Section (RFS)
  Nov. 14-16, Marriott Marquis
- Senior Physicians Section (SPS)
  Nov. 16, Manchester Grand Hyatt
- Women Physicians Section (WPS)
  Nov. 16-17, Manchester Grand Hyatt
- Young Physicians Section (YPS)
  Nov. 14-15, Marriott Marquis

Exhibits

AMA Foundation Booth
Visit the AMA Foundation booth to learn how the Foundation is improving the nation's health through its *Community Health Programs* and encouraging future physician leaders through the *Physicians of Tomorrow Scholarships* and *Leadership Development Institute.* While you're there, make sure to check out the collectible 2019 San Diego Meeting pin. Don't have time to stop by the booth? Visit online at amafoundation.org or in the AMA Meetings app.

For additional information, please call 312.464.4200 or email amafoundation@ama-assn.org.

Visit the Member Center Booth and pick up a gift!
Located between Registration and the Terrace be sure to visit the Member Center between Saturday, Nov. 16 and Tuesday, Nov. 19.

- Get assistance with membership related inquiries
- Update your AMA account to customize your news subscriptions
- Pick up a free gift
- And check out a few new surprises

Special events

AMA EXPO
Be sure to visit the AMA Expo from 1 to 6 p.m. Friday, Nov. 15 in Grand Hall C-D. The Expo will include several components:

- AMA Career Fair – Connect with recruiters to learn more about residency programs and health care institutions of varying sizes.
- AMA Group Member exhibitors – Here's the chance to market the organization to both residents and young physicians seeking career opportunities within a medical group or health system.
- AMA Research Symposium – Share your expertise and view original research from students, residents, fellows and international medical graduates.
  - The poster showcase will run from 3 to 6 p.m.
  - The poster competition will take place from 4 to 6 p.m.

Find more information about the AMA EXPO at ama-assn.org/events/ama-expo.

AMA Ambassadors lounge
Are you a proud and loyal AMA member? Are you excited to share the value of an AMA membership with your colleagues? If you answered "yes", stop by the Ambassadors Lounge in the Seaport Ballroom Foyer at the Hyatt to recharge and learn more about our AMA's newest Member Experience program.

Ambassadors lounge activities will allow you to:
- Pick-up Ambassador gifts
- Submit your Ambassador update
- Sign-up for Ambassador Training Sessions
- Network with other AMA Ambassadors and "recharge"
- Learn about the Ambassador activation app

Hours for the lounge are:
1–5 p.m. Friday, Nov. 15
9 a.m.–5 p.m. Saturday, Nov. 16
7:30 a.m.–5 p.m. Sunday, Nov. 17
9 a.m.–5 p.m. Monday, Nov. 18
8–11:30 a.m. Tuesday, Nov. 19

Questions may be emailed to J. Mori Johnson or visit ama-assn.org/ambassadors for more information and to enroll in the AMA Ambassador Program.

Free hearing tests
8–10 a.m. Saturday, Nov. 16, Mission Hills (Marriott)
Hosted by the AMA Senior Physicians Section and the American Academy of Otolaryngology-Head and Neck Surgery.

Advance registration is required by visiting surveymonkey.com/r/D5DGCQ3, and tests are available on a first-come, first-served basis.

Catholic Mass
We are trying to arrange for Catholic Mass, which would be celebrated at 6:30 p.m. Saturday, Nov. 16 in Grand Hall C.

Welcome to California Mixer!
The California Medical Association and the California Delegation to the AMA would like to invite you to a Welcome to California Mixer on the flight deck of the USS Midway (910 N. Harbor Drive). The event will be held from 6:30 to 10:30 p.m. Sunday, Nov. 17. There is no cost to attend and a complimentary shuttle will be running from the Manchester Grand Hyatt to the USS Midway. Come and enjoy heavy hors d'oeuvres, libations, and dancing on the historic USS Midway. Please make sure to wear comfortable shoes and bring a coat as it can get a little cold on the flight deck in November!

AMPAC Capitol Club luncheon
The American Medical Association Political Action Committee (AMPAC) is the bipartisan political arm of the AMA that helps elect medicine-friendly candidates running for federal office. AMPAC needs your support to have an impact on the AMA's continuing advocacy efforts in Washington, DC.

AMPAC will be hosting a private luncheon for all 2019 Capitol Club members from noon to 1:30 p.m. Monday, Nov. 18. AMPAC's special guest will be Stephen Fried, award winning journalist and New York Times best-selling author. Mr. Fried will be discussing his latest work, George Washington Book Prize finalist, *Rush*, the story of Benjamin Rush, a visionary physician and political thinker who was advisor to, and caretaker of America's first leaders. Rush served as Surgeon General of the Continental Army and as personal physician to Benjamin Franklin, George Washington, John Adams, and Thomas Jefferson; was one of the youngest signatories of the Declaration of Independence; and is one of our most provocative and unsung Founding Fathers, largely forgotten, until now. This is an event you don't want to miss!

If you are already a 2019 AMPAC Capitol Club member, please stop by the AMPAC booth to pick up your ticket to join us for this exciting discussion. As a reminder, 2019 Capitol Club Platinum members can attend an exclusive private meet and greet with Mr. Fried prior to the start of the luncheon.

If you are interested in becoming an AMPAC member or would like more information on the luncheon you can speak with an AMPAC staff member at our booth located outside of the House of Delegates meeting room from Friday, Nov. 16 through Tuesday, Nov. 19.

NOTES

The following list is provided for your convenience. All items mentioned in the *Speakers' Letter* are included along with a few other items of possible interest.

(Items listed in bold are official AMA-HOD sessions, reference committees or programs.)

Events are at the Manchester Grand Hyatt unless italicized.

Activities offering continuing medical education credit are preceded by an asterisk (*) or dagger (†).

Time	Event	Location†
	Thursday, November 14	
7 a.m.–7 p.m.	Childcare availability	Manchester Grand Hyatt
10:30 a.m.–7 p.m.	Delegate registration	Palm Foyer, Seaport Tower
1:30–2 p.m.	*You thought you only had a duty of care to your patients?*	*Marina D (Marriott)*
5 p.m.	Deadline for not for official business bag	AMA production area at Manchester Grand Hyatt
	Friday, November 15	
7 a.m.–6 p.m.	Delegate registration	Palm Foyer, Seaport Tower
7 a.m.–7 p.m.	Childcare availability	Manchester Grand Hyatt
8–8:45 a.m.	*Managing gender bias in medical careers*	*La Costa (Marriott)*
8:30–9:15 a.m.	*Adverse childhood experiences and trauma informed care for migrant populations and displaced peoples*	*Coronado (Marriott)*
8:30 a.m.-noon	*No street left behind: How integrated systems affect social determinants of health*	*Marina E (Marriott)*
9–9:45 a.m.	*La Frontera—The unknown frontier of women's health care at the US-Mexico border*	*La Costa (Marriott)*
9:15–10:15 a.m.	*Peer review survival kit: Is your peer review process safe?*	*Marina D (Marriott)*
Noon–1:15 p.m.	*Family detention in US immigration: The interface of medical ethics and advocacy*	*Marina F (Marriott)*
12:30–1:15 p.m.	*The AMA policymaking lifecycle: Turing ideas into policy and then into solutions!*	*Marina D (Marriott)*
1–1:45 p.m.	*Professionalism on social media, and its uses in networking, advocacy, and professional development*	*La Costa (Marriott)*
1-2:30 p.m.	*Employer-driven innovations: Reshaping health care delivery*	*Marina E (Marriott)*
1–5 p.m.	AMA Ambassadors lounge	Seaport Ballroom Foyer
1–6 p.m.	AMA Expo	Grand Hall C-D
1:30–2:15 p.m.	*I am human: A look at shortcomings in the United States prison health care system*	*Coronado (Marriott)*
1:30–2:30 p.m.	*The credentialing, privileging, and enrollment processes: How what you don't know can hurt you!*	*Marina D (Marriott)*
1:45–2:45 p.m.	The promise of Project ECHO as an educational paradigm	Grand Hall D
2–3 p.m.	*Seeking mental health care as physicians and future physicians*	*Marina G (Marriott)*
2–5 p.m.	OSMAP	Harbor Ballroom A-B
2:30–3:15 p.m.	*Structural violence—Understanding the bias against patients with a history of substance abuse*	*Coronado (Marriott)*
2:45–3:45 p.m.	*Demystifying employment contracts*	*Marina D (Marriott)*
3–3:45 p.m.	*Cultural humility and implicit bias: Moving toward equitable health care*	*La Costa (Marriott)*
3–4 p.m.	Recruiting, retaining, retraining, and rewarding community physicians	Grand Hall D
3:30–4:15 p.m.	*Unraveling the mysteries of surprise billing*	*Coronado (Marriott)*
4–5 p.m.	*Healthcare think tank: Members Moving Medicine*	*La Costa (Marriott)*
5 p.m.	OSMAP reception	Harbor Ballroom D-F

Locations are subject to change. All locations are in the Manchester Grand Hyatt unless otherwise specified and indicated by italics.

*, † 1 *AMA PRA Category 1 Credit*™ available for this session.

Time	Event	Location†
	Saturday, November 16	
6:45–9:30 a.m.	Surgical Caucus business meeting and Handbook review	Coronado E
7 a.m.–6 p.m.	Delegate registration	Palm Foyer, Seaport Tower
7 a.m.–7 p.m.	Childcare availability	Manchester Grand Hyatt
8-8:45 a.m.	*US health care reform—Diving into economic, physician, and patient aspects of proposed health care*	*La Costa (Marriott)*
8–10 a.m.	*Hearing tests*	*Mission Hills (Marriott)*
8:30–9:15 a.m.	*Developing sustainable global health projects in the age of voluntourism*	*Coronado (Marriott)*
9–9:45 a.m.	Amplify your voice: How physicians can shape health policy	Harbor Ballroom G-H
9–9:45 a.m.	*Identifying clinical problems and driving needs-oriented innovation in medicine*	*La Costa (Marriott)*
9 a.m.–5 p.m.	AMA Ambassadors lounge	Seaport Ballroom Foyer
9:30–10:15 a.m.	*Using cost-effectiveness to determine coverage priorities*	*Coronado (Marriott)*
9:45–11 a.m.	The new MOC: Continuing board certification	Grand Hall D
10–10:45 a.m.	*Telemedicine and mobile apps—Accessing birth control without stepping foot in a clinic*	*La Costa (Marriott)*
Noon–1:30 p.m.	The impact of vision and hearing loss in the senior population—Why seeing and hearing are believing	Grand Hall C
2–6 p.m.	**House of Delegates Opening Session**	**Seaport Ballroom**
5:15–6 p.m.	Fair market pricing for prescription drugs	Harbor Ballroom B
6–6:30 p.m.	Investigating gender bias in medical student evaluations	Harbor Ballroom A
6:30 p.m.	Catholic Mass	Grand Hall C
	Sunday, November 17	
7 a.m.–4 p.m.	Delegate registration	Palm Foyer, Seaport Tower
7 a.m.–7 p.m.	Childcare availability	Manchester Grand Hyatt
7:30 a.m.–5 p.m.	AMA Ambassadors lounge	Seaport Ballroom Foyer
8–8:30 a.m.	**AMA House of Delegates Business Session**	**Seaport Ballroom**
8:30 a.m.–noon	**Reference Committee on Amendments to Constitution and Bylaws**	**Grand Hall C**
8:30 a.m.–noon	**Reference Committee B**	**Harbor Ballroom G-I**
8:30 a.m.–noon	**Reference Committee C**	**Harbor Ballroom A-C**
8:30 a.m.–noon	**Reference Committee F**	**Seaport Ballroom**
8:30 a.m.–noon	**Reference Committee J**	**Harbor Ballroom D-F**
8:30 a.m.–noon	**Reference Committee K**	**Grand Hall D**
Noon	Deadline for election announcements to be shown at I-19	Speakers' Office
1 p.m.	Rural Health Caucus	Regatta
1 p.m.	Election Task Force open forum	Grand Hall D
1–3:30 p.m.	Health Impact of Climate Change - Preparing Your Communities and Practices	Harbor Ballroom A-B
2–2:45 p.m.	AMA Ambassador Training – Onboarding	America's Cup A-B
2–3:30 p.m.	*Training Physicians in the Art of the Public Forum	City View
2–4 p.m.	Litigation Center Open Meeting	Harbor Ballroom D-F
2:30–3:30 p.m.	Back to basics: The fundamentals of extraordinary leadership	Coronado D
3–4 p.m.	AMA Ambassador Training – Personal and professional brand	America's Cup A-B
3–4 p.m.	AMA Ambassador Training – Social media	America's Cup C-D
3–4 p.m.	AMPAC Presents an Insiders "How to" Guide to Running and Winning a Campaign	Grand Hall C
3–4:30 p.m.	Changes to Reporting Evaluation and Management Office Visits: How to Prepare for 2021	Harbor Ballroom G-I
4–5 p.m.	AMA Ambassador Training – Why are you an AMA member	America's Cup A-B
4–5 p.m.	AMA Ambassador Training – Smarp	America's Cup C-D
6:30–10:30 p.m.	*CMA Welcome to California Mixer*	*USS Midway (complimentary shuttle available)*

Locations are subject to change. All locations are in the Manchester Grand Hyatt unless otherwise specified and indicated by italics.
*, † 130 *AMA PRA Category 1 Credit™* available for this session.

Time	Event	Location†
	Monday, November 18	
7 a.m.–6 p.m.	Delegate registration	Palm Foyer, Seaport Tower
7 a.m.–7 p.m.	Childcare availability	Manchester Grand Hyatt
8–9:30 a.m.	*Training Physicians in the Art of the Public Forum	Grand Hall D
9–10 a.m.	COL Forum	Harbor Ballroom D-F
9 a.m.–5 p.m.	AMA Ambassadors lounge	Seaport Ballroom Foyer
9:30–11:30 a.m.	*CEJA Open Forum	Grand Hall C
9:30–11:30 a.m.	President's panel: Physicians' obligation to lead	Harbor Ballroom C
10–11 a.m.	†Is there a doctor on board? – Dealing with in-flight emergencies	Grand Hall D
11:30 a.m.	Private Practice Physician Congress	Harbor Ballroom A-B
Noon–1:30 p.m.	AMPAC Capitol Club Luncheon	TBD
2–6 p.m.	**House of Delegates Business Session**	**Seaport Ballroom**
	Tuesday, November 19	
7 a.m.–noon	Delegate registration	Palm Foyer, Seaport Tower
7 a.m.–noon	Childcare availability	Manchester Grand Hyatt
8–11:30 a.m.	AMA Ambassadors lounge	Seaport Ballroom Foyer
8:30 a.m.–noon	**House of Delegates Business Session**	**Seaport Ballroom**

Locations are subject to change. All locations are in the Manchester Grand Hyatt unless otherwise specified and indicated by italics.
*, † 1 *AMA PRA Category 1 Credit*™ available for this session.

This form is for Delegate and Alternate Delegate Registrants

You must complete this form and return it to staff at the AMA registration desk in San Diego to receive your credentials for the 2019 Interim Meeting of the House of Delegates. See Policy G-600.032

Name (**please print**): _____

HOD CONTACT INFORMATION

Please provide the contact information that should be used for House of Delegates business. This information will also appear in the pictorial directory unless you indicate otherwise (please print):

Mailing address: _____

City, State Zip code: _____

Phone 1: _____ Phone 2: _____

Email: _____

☐ This is an update / correction. ☐ Please do not include in pictorial directory.

EMERGENCY CONTACT INFORMATION FOR I-19

Cell phone while at meeting: _____

Emergency contact name: _____

Emergency contact phone: _____

TITLE OF THIS SECTION

I acknowledge that I have been made aware of Policy H-140.837, "Policy on Conduct at AMA Meetings and Events," and have had the opportunity to review the policy. I hereby agree to conduct myself in accord with the policy.

_____
Signature

Return this completed form at the HOD registration desk in San Diego.

Todd Askew, AMA Senior Vice President
Advocacy Group

Todd Askew is the Senior Vice President of the Advocacy Group for the American Medical Association, overseeing the organization's legislative, government affairs, political, health policy and private sector advocacy activities. Prior to becoming SVP in 2019, Todd managed the AMA's team of Congressional lobbyists as Director of Congressional Affairs, developing and implementing strategies to advance organized medicine's priorities before the United States Congress. Todd had previously served as an Assistant Director for the division. From 1994-2000, Todd worked for the American Academy of Pediatrics Department of Federal Affairs working on legislative and regulatory matters dealing with health care financing and public health, including the 1997 enactment of the Children's Health Insurance Program. He began his career in Washington in the office of then Representative Nathan Deal of Georgia. Todd has a BA in History from Washington and Lee University in Lexington, VA.

Busharat Ahmad, MD Leadership Development Program Speaker

Colonel Arthur J. Athens, USMCR (Ret.)
Biography

Colonel Athens recently left the federal government, having served for the past decade as the Director of the U.S. Naval Academy's Vice Admiral James B. Stockdale Center for Ethical Leadership and previously, as the Naval Academy's first Distinguished Military Professor of Leadership.

Colonel Athens is a retired Marine Corps officer with command and staff assignments in all four Marine Aircraft Wings and an instructor tour with Marine Aviation Weapons and Tactics Squadron One (the Marine Corps' equivalent to the Navy's Top Gun school). He also served as a White House Fellow under President Ronald Reagan and the Special Assistant to the NASA Administrator following the Space Shuttle Challenger accident.

Colonel Athens currently speaks around the country about leading with integrity and works alongside leaders to help them fulfill their personal and professional calling.

He is married to the former Mistina Root of Williamsburg, Virginia and they have ten children.

Announcements

Message from the Chair
IMGS Governing Council Roster
Join a Committee
Leadership opportunities
Mentor signup
Future meetings

Message from the Chair

Dear IMG Section Members,

As a Chair of the AMA-IMG section, it is an honor, and privilege to serve you. In the last 6 months, we have accomplished a lot. We have launched the celebration of "AMA-IMG week" Which showcased the value and achievements of IMG physicians, highlighted an animated video with quotes from various IMG physicians, offered a special interview with leadership from the IMG and Resident and Fellows Sections, digital ads were provided, promotion was on social media and lots more.

As a section, we not only approached every medical ethnic society to integrate them under one umbrella of the AMA-IMG section but also welcomed every AMA delegate and alternate delegate who is an IMG. We will continue to collaborate with other sections and medical society leaders. The Section's work depends entirely on the efforts of not just the members but also of the Board of Trustee liaisons, and our AMA staff. The Section developed its Strategic Plan to build upon in order to continue to flourish in the IMG Section.

I would like to personally welcome you to the 22nd Interim Meeting of the American Medical Association International Medical Graduates Section (IMGS). I look forward to seeing you and for your convenience, I have outlined an overview of the key IMG events.

Thank you for your participation in the Interim Meeting. We are only good as those around us and we can achieve more as a team. We hope that you will continue to stay involved in the IMG Section policymaking and other events. There are also Committees available for you to join. For more information, email img@ama-assn.org

Together, we are stronger. We look forward to seeing you June 5-9, 2020 in Chicago.

Sincerely,

Kevin King MD, Chair

2019 AMA-IMGS Governing Council

Kevin King, MD, Chair
Colonel Ronit Katz, MD, Delegate
Kamalika Roy, MD, Alternate Delegate
Ricardo Correa, MD, Member At-Large
Subhash Chandra, MD, Immediate Past Chair
Sabesan Karuppiah, Member At-Large

Deepak Kumar, MD, Chair-Elect
Toms Vengaloor Thomas, MD, Resident/Fellow

Schedule: You will find a copy of the most current schedule in your agenda book, page 27.

IMGS Congress and Educational Program, Addressing the Challenge of **Equitable Drug Pricing in the Era of Precision Medicine"**

Join the IMG Section as we network with colleagues and discuss policy initiatives. Come hear guest speaker, Todd Askew, AMA Senior Vice President of Advocacy, discuss the legislation for equitable drug pricing and the International Pricing Index.

> The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
>
> The American Medical Association designates this CME activity for a maximum of 1.0 AMA PRA Category 1 Credit(s)TM. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Joint AMA-IMG Section (IMGS) and Women Physicians Section (WPS) Reception

Saturday, November 16, 7:00 pm – 8:30 pm – Harbor A

Busharat Ahmad, MD Leadership Development Program: "Back to the **Basics: The Fundamentals of Extraordinary Leadership"**

Join the IMG Section in its leadership initiative as guest speaker, Colonel Arthur Athens, talk about the four leadership fundamentals that differentiate extraordinary leaders from ordinary leaders on Sunday, November 17, 2:30 – 3:30 pm in Coronado D.

> The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.
>
> The American Medical Association designates this CME activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AMA-IMGS & Minority Affairs Delegates Caucus
9:00-10:00 a.m. – Monday, Nov. 18 – City View A/B

Attend the joint IMGS/MAS Delegates Caucus to review Reference Committee reports and discuss strategies for supporting IMG Section and House of Delegates policy items.

AMA House of Delegates opening session: The AMA House of

Delegates will meet Saturday, November 16 through Tuesday, November 19. More information has been included in the IMG Section schedule and Meeting APP. If you have questions, please contact Carolyn Carter-Ellis at carolyn.carter-ellis@ama-assn.org

Resolutions: The deadline for resolutions for the 2020 Annual Meeting will be April 1. If you wish to submit a resolution, please follow the resolution process as outlined in your handbook. For further assistance with AMA policy or other aspects of your resolution, contact Carolyn Carter-Ellis, (312) 464-5397.

AMERICAN MEDICAL ASSOCIATION
INTERNATIONAL MEDICAL GRADUATES SECTION
2019-2020 Governing Council Roster

Subhash Chandra, MD, FAPA, Immediate Past Chair	Email: schandra2@yahoo.com – preferred email
Ricardo Marquez Correa, MD	Email: riccorrea20@hotmail.com
Colonel Ronit Katz, MD	Email: rkatz1@stanford.edu
Kevin King MD, FACEP, AACEM, Chair	Email: kking1@geisinger.edu;
Sabesan Karuppiah, MD, MPH, FAAFP	Email: sabesan@yahoo.com
Deepak Kumar, MD,	Email: deepkmr@aol.com
Kamalika Roy, MD	Email: drkamalika@gmail.com; royk@ohsu.edu
Toms Vengaloor Thomas MD, Resident/Fellow	Email: tomsvthomas@gmail.com
S. Bobby Mukkamala, MD, Board Liaison Karen Fuss, Executive Assistant	Office: (312) 464-4469 Email: karen.fuss@ama-assn.org
Susan R. Bailey, MD, Board Liaison, AMA President-Elect Robin Russell, Executive Assistant	Office: (312) 464-4467 Email: robin.russell@ama-assn.org

Keith Voogd, Director, Governance and Policy AMA Plaza 330 North Wabash Chicago, IL 60611	Office: (312) 464-4539 Fax: (312) 224-6908 Email: keith.voogd@ama-assn.org
Carolyn Carter-Ellis, MBA, Sr. Group Manager, IMGS AMA Plaza 330 North Wabash Chicago, IL 60611	Office: (312) 464-5397 Fax: (312) 224-6906 Cell: (708) 724-7974 Email: carolyn.carter-ellis@ama-assn.org
Georgianne Cooper, Staff Assistant II AMA Plaza 330 North Wabash Chicago, IL 60611	Office: (312) 464-5622 Fax: (312) 464-2450 Email: georgianne.cooper@ama-assn.org

2019 AMA-IMGS COMMITTEES

I. **Acculturation Committee – ON HOLD**

Chair, Guillermo Godoy, MD; Email: guillermo461@comcast.net**; Bhushan Pandya, MD – Co-Chair, Email:** bhpmd2004@yahoo.com

Mission:

- To provide assistance with the integration of International Medical Graduates into American medicine to improve patient care and health outcomes
- Help the American Medical community understand the challenges overcome by IMGs
- Establish awareness as well as demonstrate the diversity brought by IMGs.
- Identify opportunities to help IMGs get familiar with the American Medical culture and opportunities for the American physicians to understand and appreciate the value and challenges of different cultures
- Develop an acculturation module resource

II. **Resolutions and Reports Policy Committee:**

Chair: Colonel Ronit Katz, MD, Delegate, E-mail: rkatz1@stanford.edu
Kamalika Roy, MD, Alternate Delegate, E-mail: drkamalika@gmail.com

Mission:

- Develop at least 3 well-written and researched reports or resolutions for the Interim and Annual HOD meetings.
- Identify two issues that require AMA IMGS advocacy efforts

III. **Nominating Committee:**

Chair: **Subhash Chandra MD, E-mail:** schandra2@yahoo.com

Mission:

- Recruit a diverse pool of candidates for the IMGS GC elections.
- Present a diverse slate for the 2019 IMGS GC online ballot.
- Validate 2019 election winners

IV. **Leadership Development Program, Chair**: : **Subhash Chandra MD, E-mail:** schandra2@yahoo.com

Mission:

- Recruit at least 10 diverse committee members
- Develop the program/speaker for the Busharat Ahmad, MD Leadership Program for the Interim and Annual meeting.
- Discover what resources or tools IMGs need in order to ascend into leadership positions

V. **Desserts Reception (AMA-IMG staff) –** img@ama-assn.org

Mission:

- Assist in the development and promotion of the Annual Desserts From Around the World Reception for June event

VI. **Social Media, Toms Vengaloor Thomas, MD, Chair;** tomsvthomas@gmail.com

Mission:

- To develop team of Committee members to devise ideas for social media regarding IMGS. Ideas will be transmitted to IMG staff and AMA digital strategy.

VII. **US IMGS Special Interest Group, IMG staff: Email: img@ama-assn.org**

Mission:
This AMA-USIMG program is dedicated to U.S. citizens and permanent residents who are attending medical school in the Caribbean and have not yet obtained their ECFMG certification. Through this new program, students are invited to become involved with the AMA and obtain the following benefits:

- Learn how patients and physicians benefit from the advocacy efforts of the IMG Section;
- Take advantage of networking opportunities with other students, resident physicians and practicing physicians;
- Enjoy instant access to the AMA Medical Student Section (MSS) and IMGS;
- Attend the Annual and Interim meetings of the AMA-MSS and IMGS including the annual AMA-IMGS Symposium;
- View webinars and videos showcasing practical tips for a successful residency program Match;
- Stay current on how the ECFMG certification process works;
- Gain valuable practice through our mock residency program interview opportunities; and
- Obtain financial planning resources and loan consolidation information to help ease worries about debt.

To register for USIMG Committee, visit
https://app.cvent.com/Reports/Welcome.aspx?p=8060a9d5-f0ac-4a47-b8bd-1ab9e689b53f

VIII. **USIMG Committee** –

Chair, Ricardo Correa, MD; Email: riccorrea20@hotmail.com**;**

Mission:

- Engage USIMGs by providing outreach and have more standardized approach
- Determine needs of USIMGs
- Work with residents, physicians and alumni associations

2019-2020 AMA COUNCIL/COMMITTEE LEADERSHIP OPPORTUNITIES

For additional information, please contact Carolyn Carter-Ellis, Sr. Group Manager, IMGS, carolyn.carter-ellis@ama-assn.org (800) 262-3211, 5397

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
CPT Editorial Panel		BOT	Four Years/One or Two Terms	June	2020	Jayesh Shah, MD
CPT Advisory Committee		BOT	Two Years	November		Bindu Kansapada, MD
Residency Review Committees (28)		BOT	Two Years/Three Terms	April/As Needed	March 1, 2020	Ved Gossain, MD (IM), Kevin
American Boards (19 of 24)		BOT	Varied	As Needed	March 1, 2020	June-Anne Gold, MD, Ricardo
AAHC/URAC Board of Directors		BOT	Three-Years	June		
Accreditation Council for Graduate Medical Education		Nominated by BOT, Elected by ACGME	Three Years/Two Terms	June	March 1, 2020	Drs. Kiran Shah, Jayesh Shah, Milton Kramer, R. Correa, MD
National Patient Safety Foundation		BOT	Three Years	June		Kiran Shah, MD
Practice Expense Advisory Committee (subcommittee of the RUC)		BOT	Four Years	June		Drs. Niranjan Rao, Jose David
AMA/Specialty Society RVS Update Committee		BOT	Three Years/Two Terms Two Years/Three Terms for Chair	June/December		Deepak Kumar, MD
AMA Foundation		BOT	Three Years/Two Terms	June/October		Jayesh Shah, MD, R. Correa,
Accreditation Coun. for Contin. Med. Educ.		BOT	One Year/Six Terms	October		Ricardo Correa, MD
Accreditation Council for Continuing Medical Education Review Committee		BOT	One Year/Six Terms	October		Gamini Soori, MD Ved Gossain, MD
Accreditation Review Committee for the Physician Assistant		BOT	Three Years/Two Terms	October		
Advisory Committee on Group Practice		BOT	Two Years	October		
American Board of Medical Specialties		BOT	Four Years/Two Terms	October		Gamini Soori, MD Ved Gossain, MD Ricardo Correa, MD
Commission on Accreditation of Allied Health Education Programs		BOT	One Year/Six Terms	October		Jose David, MD
Educational Commission for Foreign Medical Graduates		BOT	Four Years/Two Terms	October		Drs. Soori, Wollschlaeger, Jayasankar, Milton Kramer, Appareddy, R. Correa, Subhash Chandra, B. Kansapada

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
E-Medicine Advisory Committee		BOT	Two Years	October		Keith Adams, MD
The Joint Commission		BOT	Three Years	October	2020	Drs. Kiran Shah, Ricardo Correa
Liaison Committee on Medical Education (students)		BOT	One Year/Six Terms	April		Kevin King, MD
National Board of Medical Examiners		BOT	Four Years/Two Terms	October		Mitra Kalelkar, MD, Ricardo Correa
National Resident Matching Program		BOT	Three Years/Two Terms	October		Gamini Soori, MD, Nirav Shah, MD, Ricardo Correa,
ACGME Institutional Review Committee		Nominated by BOT, Elected by ACGME	Two Years	December		Gamini Soori, MD, Ricardo Correa, MD
JAMA Oversight Committee		BOT	Three Years/Two Terms	December		Ricardo Correa, MD
Joint Commission PTACS Ambulatory Care Behavioral Health Home Care Hospital Long Term Care		BOT	Two Years/Three Terms	December	March 1, 2020	
U.S. AN Council		BOT	One Year/Ten Terms	December		

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
U.S. AN Review Board		BOT	One Year/Ten Terms	December		
Council on Constitution and Bylaws	Patricia L. Austin, MD, Chair (2022) Mark N. Bair, MD (2027) Madelyn E. Butler, MD (2022) Jerome C. Cohen, MD, Chair (2021) Pino D. Colone, MD (2020) Lisa Bohman Egbert, MD (2023)* Pauline P. Huynh (Student) (2020)* Ariel M. Anderson MD (Resident) (2024) Kevin C. Reilly, Sr. (2026)* Bruce A. Scott, MD (2023)*	Candidates approved by BOT/Elected by HOD	Four Years/Two Terms	February	March 15, 2020	
Council on Ethical & Judicial Affairs	Rebecca W. Brendel, MD (2026)* Kimberly A. Chernoby, MD (Resident) (2024) David A. Fleming, MD (2024)* Jeremy Lazarus, MD (2025)* Kathryn L. Moseley, MD,MPH,FAAP, Chair (2020) Michael J. Rigby, MD (Student) (2023)* Alexander Rosenau, DO,CPE (2022)* Peter A. Schwartz, MD (2023)* Monique A. Spillman, MD, Vice Chair (2021)	President/Elected by HOD	Seven Years/One Term	June	March 15, 2020	

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
Council on Medical Education	Jacqueline A. Bello, MD, Chair (2021) Kelly Caverzagie, MD (2027)* Sharon P. Douglas, MD (2027)* Robert Goldberg, MD (2021) Cynthia A. Jumper, MD (2020) Sharon Kilgore, MD (2027)* Liana Puscas, MD, Chair-Elect (2021) Niranjan V. Rao, MD, (2022) Luke V. Selby, MD, (Resident) (2020) Krystal L. Tomei, MD (2021) Rafa Rahman (Student) (2020)* John P. Williams, MD, (2023)*	Candidates approved by BOT/Elected by HOD	Four Years/Two Terms	February	March 15, 2020	Jayesh Shah, MD, June-Anne Gold, MD; Subhash Chandra, MD
Council on Medical Service	A Patrice Burgess, MD (2027)* Betty S. Chu, MD (2026)* Alice Coombs, MD (2027)* Meena Davuluri, MD (Resident) (2020) Stephen K. Epstein, MD (2022) W. Alan Harmon, MD, Chair (2020) Lynn L. C. Jeffers, MD (2020) Asa C. Lockhart, MD (2022) Thomas Madejski, MD (2023)* Sheila Rege, MD (2022) Nonie Arora (Student) (2020) Lynda M. Young, MD, Chair-Elect (2021)*	Candidates approved by BOT/Elected by HOD	Four Years/Two Terms	February	March 15, 2020	

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
Council on Legislation	David H., Aizuss, MD (2025)* VijayaLakshmi Appareddy, MD (2026)* Maryanne Bombaugh, MD (2027)* Mary S. Carpenter, MD (2023)* Marilyn J. Heine, MD, Vice Chair (2022) Elizabeth A. Irish, Alliance Representative (2021) Gary W. Floyd, MD (2025)* Tripti Kataria, MD (2026)* Ajeet Singh (Student) (2020) Linda B. Ford, MD, AMPAC Board Observer (11/20) Heather Ann Smith, MD (2023)* David T. Tayloe, Jr.,MD, Chair (2019) Marta Van Beek, MD (2026)* Hans Arora, MD, Resident (2025)*	BOT	One Year/Eight Terms	April	March 15, 2020	Drs. S. Jayasankar, Deepak Kumar, MD

Council on Science and Public Health	John T. Carlo, MD (2025)* Kira A. Geraci-Ciardullo, MD, Chair-Elect (2022) Noel Deep, MD (2023)* Alexander Ding, MD (2024)* Ali Bokhari, Student (2020)* Mary E. LaPlante, MD (2025)* Laura Halpin MD, Resident (2020) Michael M. Miller, MD, Chair (2022) Corlis Varnum, MD (2027)* Padmini Ranasinghe, MD (2026)* Tamaan Osbourne-Roberts, MD (2027)* David J. Welsh, MD (2020)	BOT	Four Years/Two Terms	April	March 15, 2020	June-Anne Gold, MD

Entity	Council Members (Expiration Dates)	Appointed by	Length of Term/Maximum	BOT Review Date	Nomination Deadline	IMGs Interested
Council on Long Range Planning & Development	Michelle A. Berger, MD (2026)* Edmond Cabbabe, MD (2025)* Clarence P. Chou, MD (2024)* James A. Goodyear, MD, Chair (2021) Rebecca Haines (Student) (2020) Jan M. Kief, MD (2027)* G. Sealy Massingill, MD (2027)* Benjamin Meyer, MD (Resident) (2025)* Shannon P. Pryor, MD. Vice Chair (2024) Gary Thal, MD (2025)*	BOT & HOD Speaker	Four Years/Two Terms	April	March 15, 2020	Jayesh Shah, MD
American Medical Political Action Committee	Grayson W. Armstrong, MD (Resident), (2020) Miriam Bareman, (Student) (2020) Brooke M. Buckley, MD, (2024) Paul J. Carniol, MD (2026) Linda B. Ford, MD, Observer (2020) Benjamin Z. Galper, MD (2024) Dev. A. GnanaDev, MD, (2020) Stephen A. Imbeau, MD (Secretary) (2022) James L. Milam, MD (2022) L. Elizabeth Peterson, MD (2026) Michael Suk, MD (2024) Lyle S. Thorstenson, MD (Chair) (2020)*	BOT	Two Years/Four Terms		Renews every two years – Next due date: July 15, 2020	Deepak Kumar, MD, Bindu Kansapada, MD

AMA
AMERICAN MEDICAL ASSOCIATION

INTERNATIONAL MEDICAL GRADUATES SECTION

SIGN UP TO BECOME A MENTOR

NAME	EMAIL ADDRESS	TELEPHONE NUMBER

MEMBERS MOVE MEDICINE℠

International Medical Graduates Section

Future meetings

A. State Advocacy Summit – January 9-12, 2020, Bonita Springs, FL

B. February 10-12, National Advocacy Conference, Washington, DC

C. June 4-8, 2020, IMG Section 23rd Annual Meeting, Hyatt Regency Chicago

D. July 17-19, 2020 Sections & Special Groups Leadership Retreat, Chicago (*tentative)*

E. November 12-16, 2020 - IMG Section 23rd Interim Meeting, Manchester Grand Hyatt/Convention Center, San Diego, California