

DISCLAIMER

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-19)

Report of Reference Committee C

Louito C. Edje, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

2

3 **RECOMMENDED FOR ADOPTION**

4

5 1. Resolution 301 – Engaging Stakeholders for Establishment of a Two-Interval, or
6 Pass/Fail, Grading System of Non-Clinical Curriculum in U.S. Medical Schools
7 2. Resolution 303 – Investigation of Existing Application Barriers for Osteopathic
8 Medical Students Applying for Away Rotations
9 3. Resolution 308 – Study Expediting Entry of Qualified IMG Physicians to US Medical
10 Practice

11

12 **RECOMMENDED FOR ADOPTION AS AMENDED**

13

14 4. Council on Medical Education Report 3 – Standardization of Medical Licensing Time
15 Limits Across States (Resolution 305-A-18)
16 5. Council on Medical Education Report 4 – Board Certification Changes Impact
17 Access to Addiction Medicine Specialists (Resolution 314-A-18)
18 6. Council on Medical Education Report 6 – Veterans Health Administration Funding of
19 Graduate Medical Education (Resolution 954-I-18)
20 7. Resolution 302 – Strengthening Standards for LGBTQ Medical Education
21 8. Resolution 305 – Ensuring Access to Safe and Quality Care for our Veterans
22 9. Resolution 310 – Protection of Resident and Fellow Training in the Case of Hospital
23 or Training Program Closure

24

25 **RECOMMENDED FOR ADOPTION IN LIEU OF**

26

27 10. Council on Medical Education Report 2 – Healthcare Finance in the Medical School
28 Curriculum (Resolution 307-A-18)
29 Resolution 307 – Implementation of Financial Education Curriculum for Medical
30 Students and Physicians in Training

31

32 **RECOMMENDED FOR REFERRAL**

33

34 11. Resolution 304 – Issues with the Match, The National Residency Matching Program
35 (NRMP)
36 12. Resolution 309 – Follow-up on Abnormal Medical Test Findings

- 1 The following resolution was handled via the reaffirmation consent calendar:
- 2
- 3 Resolution 306 – Financial Burden of USMLE Step 2 CS on Medical Students

1 RECOMMENDED FOR ADOPTION 2

3 (1) RESOLUTION 301 – ENGAGING STAKEHOLDERS FOR
4 ESTABLISHMENT OF A TWO-INTERVAL, OR
5 PASS/FAIL, GRADING SYSTEM OF NON-CLINICAL
6 CURRICULUM IN U.S. MEDICAL SCHOOLS

7
8 **RECOMMENDATION:**
9

10 **Resolution 301 be adopted.**

11
12 **HOD ACTION: Resolution 301 adopted**

13
14 RESOLVED, That our American Medical Association amend Policy H-295.866 by addition
15 and deletion to read as follows:

16
17 Supporting Two-Interval Grading Systems for Medical Education, H-295.866
18 Our AMA will work with stakeholders to encourage the establishment of acknowledges the
19 benefits of a two-interval grading system in medical colleges and universities in the United
20 States for the non-clinical curriculum. (Modify Current HOD Policy)

21
22 Your Reference Committee heard mixed testimony that was largely in favor of adoption,
23 due chiefly to the negative emotional and physical health impacts of grades on students.
24 Testimony was provided noting that studies show that students in pass/fail grading
25 systems for preclinical curricula exhibit better mental health and greater satisfaction
26 compared to those in multi-tiered grading systems. Furthermore, the widespread adoption
27 of pass/fail curriculum has not been found to negatively affect student performance on
28 United States Medical Licensing Examination Step 1 and Step 2 examinations. Those
29 providing testimony in opposition to adoption argued for the need for flexibility among the
30 individual needs of a given medical school. As with curricular mandates, the AMA should
31 not propagate a monolithic system of pass/fail grading in all medical schools—which could
32 also make it more difficult for program directors to distinguish the qualifications of one
33 school's applicants from another. Furthermore, with anticipated changes to the grading
34 and scoring of USMLE Step 1, program directors may very well need this data point to
35 evaluate residency candidates. The AMA should help schools maintain flexibility in
36 appropriate stratification and evaluation of student performance. With these caveats in
37 mind, your Reference Committee nonetheless believes that the weight of the testimony
38 supports adoption. A holistic approach to review of residency program applicants is
39 needed; this resolution helps move the AMA towards this laudable goal. Further, the
40 current policy already acknowledges the benefits of a pass/fail system; the resolution
41 simply moves the ball down the field (versus punting) and helps move the policy from
42 words to action. For these reasons, we urge adoption of Resolution 301 as written.

1 (2) RESOLUTION 303 – INVESTIGATION OF EXISTING
2 APPLICATION BARRIERS FOR OSTEOPATHIC
3 MEDICAL STUDENTS APPLYING FOR AWAY
4 ROTATIONS

5
6 **RECOMMENDATION:**

7
8 **Resolution 303 be adopted.**

9
10 **HOD ACTION: Resolution 303 adopted**

11
12 RESOLVED, That our American Medical Association work with relevant stakeholders to
13 explore reasons behind application barriers that result in discrimination against
14 osteopathic medical students when applying to elective visiting clinical rotations, and
15 generate a report with the findings by the 2020 Interim Meeting. (Directive to Take Action)

16
17 Your Reference Committee heard supportive online and in-person testimony regarding
18 Resolution 303. As noted in testimony, this resolution identifies the significant challenges
19 that osteopathic medical students face when pursuing clinical rotations away from their
20 home educational campus. The resolution's authors identified potential and real sources
21 of discrimination among MD and DO students, which is averse to AMA policies that call
22 for fairness balanced with flexibility. Speakers also noted the potential for unequal
23 treatment by some institutions, such that osteopathic medical students bear the brunt of
24 higher rotation fees versus their allopathic colleagues when applying for away rotations
25 through the Visiting Student Application Services program. This is a complex issue with
26 shades of nuance, meriting a full examination and study by our AMA Council on Medical
27 Education, to forfend ongoing adverse consequences for osteopathic medical students.
28 Therefore, your Reference Committee recommends that Resolution 303 be adopted.

29
30 (3) RESOLUTION 308 – STUDY EXPEDITING ENTRY OF
31 QUALIFIED IMG PHYSICIANS TO US MEDICAL
32 PRACTICE

33
34 **RECOMMENDATION:**

35
36 **Resolution 308 be adopted.**

37
38 **HOD ACTION: Resolution 308 adopted**

39
40 RESOLVED, That our American Medical Association study and make recommendations
41 for the best means for evaluating, credentialing and expediting entry of competently
42 trained international medical graduate (IMG) physicians of all specialties into medical
43 practice in the USA. (Directive to Take Action)

44
45 Your Reference Committee received online and in-person testimony in overwhelming
46 support of Resolution 308. Speakers noted that this resolution, which calls for a study, will
47 evaluate how "qualified" foreign-born international medical graduates (IMGs) can be
48 placed into an expeditious pathway of learning the American health care system while
49 fulfilling credentialing, licensure, and certification requirements. Speakers noted the
50 diverse educational and professional experiences that foreign-born IMGs offer and were

1 supportive of expediting the process of entry for those deemed to have the appropriate
2 knowledge and skills required for US medical practice. Speakers also noted that this study
3 is important to prevent the possibility of a tiered level of physician credentialing and to
4 ensure high quality medical care regardless of the patient's geographic location.
5 Therefore, your Reference Committee recommends that Resolution 308 be adopted.

1 RECOMMENDED FOR ADOPTION AS AMENDED

2
3 (4) COUNCIL ON MEDICAL EDUCATION REPORT 3 –
4 STANDARDIZATION OF MEDICAL LICENSING TIME
5 LIMITS ACROSS STATES (RESOLUTION 305-A-18)

6 RECOMMENDATION A:

7
8
9 Recommendation 1 in Council on Medical Education
10 Report 3 be amended by deletion, to read as follows:
11

12 1. That our American Medical Association (AMA)
13 urge the state medical and osteopathic boards that
14 maintain a time limit for completing licensing
15 examination sequences for either USMLE or COMLEX
16 to adopt a time limit of no less than 10 years for
17 completion of the licensing exams ~~to allow sufficient~~
18 ~~time for individuals who are pursuing combined~~
19 ~~degrees (e.g, MD/PhD). (New HOD Policy)~~

20 RECOMMENDATION B:

21
22
23 Recommendation 3 in Council on Medical Education
24 Report 3 be deleted:
25

26 3. ~~That our AMA encourage uniformity in the time~~
27 ~~limit for completing the licensing examination~~
28 ~~sequence across states, allowing for improved inter-~~
29 ~~state mobility for physicians. (New HOD Policy)~~

30 RECOMMENDATION C:

31
32
33 Recommendations in Council on Medical Education
34 Report 3 be adopted as amended and the remainder of
35 the report be filed.
36

37 HOD ACTION: Recommendations in Council on Medical
38 Education Report 3 adopted as amended and the
39 remainder of the report be filed

40
41 The Council on Medical Education recommends that the following recommendations be
42 adopted in lieu of Resolution 305-A-18 and the remainder of the report be filed.
43

44 1. That our American Medical Association (AMA) urge the state medical and osteopathic
45 boards that maintain a time limit for completing licensing examination sequences for
46 either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion
47 of the licensing exams to allow sufficient time for individuals who are pursuing
48 combined degrees (e.g, MD/PhD). (New HOD Policy)

- 1 2. That our AMA urge that state medical and osteopathic licensing boards with time limits
- 2 for completing the licensing examination sequence provide for exceptions that may
- 3 involve personal health/family circumstances. (New HOD Policy)
- 4
- 5 3. That our AMA encourage uniformity in the time limit for completing the licensing
- 6 examination sequence across states, allowing for improved inter-state mobility for
- 7 physicians. (New HOD Policy)

8
9 Testimony was offered in unanimous support of the first and second recommendations in
10 Council on Medical Education Report 3. Speakers noted that seven-year limits on
11 licensure eligibility becomes problematic for medical students who need to take leaves of
12 absence or for those pursuing dual degrees in a state that does not grant exception for
13 these students. One speaker offered testimony to amend Recommendation 3 to set a floor
14 on the time limit to avoid states implementing a uniform but lower limit that could negatively
15 impact trainees in a single-degree program. However, the deletion made to the first
16 recommendation extended the time limits for all licensure candidates and eliminated the
17 need for the third recommendation. Therefore, your Reference Committee encourages
18 adoption as amended of the recommendations in Council on Medical Education Report 3.

19
20 (5) COUNCIL ON MEDICAL EDUCATION REPORT 4 –
21 BOARD CERTIFICATION CHANGES IMPACT ACCESS
22 TO ADDICTION MEDICINE SPECIALISTS (RESOLUTION
23 314-A-18)

24
25 **RECOMMENDATION A:**

26
27 **Council on Medical Education Report 4 be amended by**
28 **the addition of a third Recommendation, to read as**
29 **follows:**

30
31 **That our AMA recognize the American Osteopathic**
32 **Association Bureau of Osteopathic Specialists for**
33 **developing and providing a pathway for all qualified**
34 **physicians to obtain subspecialty certification in**
35 **addiction medicine, in order to improve access to care**
36 **for patients with substance use disorder. (Directive to**
37 **Take Action)**

38
39 **RECOMMENDATION B:**

40
41 **Council on Medical Education Report 4 be amended by**
42 **the addition of a fourth Recommendation, to read as**
43 **follows:**

44
45 **That our AMA recognize the American Osteopathic**
46 **Association (AOA) for developing and providing a**
47 **pathway for qualified physicians (DOs and MDs) with an**
48 **active primary AOA board certification in any specialty**
49 **to obtain subspecialty certification in Addiction**
50 **Medicine, in order to improve access to care for**

1 **patients with substance use disorder. (Directive to Take**
2 **Action)**

3
4 **RECOMMENDATION C:**

5
6 **Recommendations in Council on Medical Education**
7 **Report 4 be adopted as amended and the remainder of**
8 **the report be filed.**

9
10 **HOD ACTION: Recommendations in Council on Medical**
11 **Education Report 4 adopted as amended and the**
12 **remainder of the report be filed**

13
14 The Council on Medical Education recommends that the following recommendations be
15 adopted in lieu of Resolution 314-A-18 and the remainder of the report be filed.

16
17 1. That our American Medical Association (AMA) recognize the American Board of
18 Preventive Medicine (ABPM) for developing and providing pathways for all qualified
19 physicians to obtain ABMS-approved certification in the new ABPM subspecialty of
20 addiction medicine, in order to improve access to care for patients with substance use
21 disorder. (Directive to Take Action)

22
23 2. That our AMA rescind Policy H-300.962 (3) "Recognition of Those Who Practice
24 Addiction Medicine," since the ABPM certification examination in addiction medicine
25 is now offered. (Rescind HOD Policy)

26
27 Your Reference Committee heard mostly supportive testimony favoring adoption of
28 Council on Medical Education Report 4, which calls attention to the urgent need to train
29 physicians in addiction medicine and recognizes the American Board of Preventive
30 Medicine for providing a time-limited pathway for subspecialty certification in addiction
31 medicine for the American Board of Addiction Medicine diplomates. In online and in-
32 person testimony, speakers also noted that the American Osteopathic Association (AOA)
33 and the AOA Bureau of Osteopathic Specialists have both developed and are
34 independently providing a pathway for all qualified physicians to obtain subspecialty
35 certification in addiction medicine. One speaker offered recommendations that asked the
36 AMA to encourage hospitals and health systems to establish departments or sections of
37 addiction medicine and to delineate clinical privileges in addiction medicine. However, a
38 member of the Council on Medical Education testified that these additional
39 recommendations could potentially lead to confusion of credentialing with certification.
40 Therefore, your Reference Committee recommends that Council on Medical Education
41 Report 4 be adopted as amended.

1 (6) COUNCIL ON MEDICAL EDUCATION REPORT 6 –
2 VETERANS HEALTH ADMINISTRATION FUNDING OF
3 GRADUATE MEDICAL EDUCATION (RESOLUTION 954-
4 I-18)

5
6 **RECOMMENDATION A:**

7
8 **Recommendation 1 in Council on Medical Education**
9 **Report 6 be amended by addition and deletion, to read**
10 **as follows:**

11
12 **That our AMA support postgraduate medical education**
13 **service obligations through any programs where the**
14 **expectation for service, such as military service, is**
15 **reasonable and explicitly delineated in the contract with**
16 **the trainee. (New HOD Policy)**

17
18 **RECOMMENDATION B:**

19
20 **Recommendations in Council on Medical Education**
21 **Report 6 be adopted as amended and the remainder of**
22 **the report be filed.**

23
24 **HOD ACTION: Recommendations in Council on Medical**
25 **Education Report 6 adopted as amended and the**
26 **remainder of the report be filed**

27
28 The Council on Medical Education recommends that the following recommendations be
29 adopted in lieu of Resolution 954-I-18 and the remainder of the report be filed.

30
31 1. That our AMA support postgraduate medical education service obligations through any
32 program where the expectation for service is explicitly delineated in the contract with
33 the trainee. (New HOD Policy)

34
35 2. That our American Medical Association (AMA) oppose the blanket imposition of
36 service obligations through any program where physician trainees rotate through the
37 facility as one of many sites for their training. (New HOD Policy)

38
39 Testimony was offered online and in-person in unanimous support of Council on Medical
40 Education Report 6. Speakers noted that this report ensures support for postgraduate
41 medical education service obligations, where that expectation is explicitly delineated in a
42 trainee's contract, and opposition to a "blanket imposition" of service obligations on
43 physician trainees who simply rotate through a Veterans Health Administration facility as
44 one of their training sites. Speakers also offered an amendment to clarify that this report
45 focuses on military service, since the Council on Medical Education will address other
46 types of services in an upcoming report on graduate medical education and the corporate
47 practice of medicine planned for the 2020 Annual Meeting. Therefore, your Reference
48 Committee recommends that Council on Medical Education Report 6 be adopted as
49 amended.

1 (7) RESOLUTION 302 – STRENGTHENING STANDARDS
2 FOR LGBTQ MEDICAL EDUCATION

3
4 RECOMMENDATION A:

5
6 Resolution 302 be amended by addition and deletion, to
7 read as follows:

8
9 RESOLVED, That our AMA amend policy H-295.878,
10 “Eliminating Health Disparities - Promoting Awareness
11 and Education of Lesbian, Gay, Bisexual, Transgender
12 and Queer (LGBTQ) Health Issues in Medical
13 Education,” by addition and deletion to read as follows:

14
15 Our AMA: (1) supports the right of medical students and
16 residents to form groups and meet on-site to further
17 their medical education or enhance patient care without
18 regard to their gender, gender identity, sexual
19 orientation, race, religion, disability, ethnic origin,
20 national origin or age; (2) supports students and
21 residents who wish to conduct on-site educational
22 seminars and workshops on health issues in Lesbian,
Gay, Bisexual, Transgender and Queer
communities related to sexual orientation and gender
identity; and (3) encourages ~~the Liaison Committee on~~
~~Medical Education (LCME), the American Osteopathic~~
~~Association (AOA), and the Accreditation Council for~~
~~Graduate Medical Education (ACGME) medical~~
~~education accreditation bodies to both continue to~~
~~encourage and periodically reassess~~ include Lesbian,
23 ~~Gay, Bisexual, Transgender and Queer education on~~
24 ~~health issues related to sexual orientation and gender~~
25 ~~identity in the basic science, clinical care, and cultural~~
26 ~~competency curriculum curricula for both in~~
27 ~~undergraduate and graduate medical education; and~~ (4)
28 ~~encourages the Liaison Committee on Medical~~
29 ~~Education (LCME), American Osteopathic Association~~
30 ~~(AOA), and Accreditation Council for Graduate Medical~~
31 ~~Education (ACGME) to periodically reassess the~~
32 ~~current status of curricula for medical student and~~
33 ~~residency education addressing the needs of pediatric~~
34 ~~and adolescent Lesbian, Gay, Bisexual, Transgender~~
35 ~~and Queer patients.~~

36
37 RECOMMENDATION B:

38
39 Resolution 302 be adopted as amended.

1 **RECOMMENDATION C:**

2
3 **The title of Policy H-295.878 be changed, to read as**
4 **follows:**

5
6 **Eliminating Health Disparities - Promoting Awareness**
7 **and Education of Sexual Orientation and Gender**
8 **Identity Health Issues in Medical Education**

9
10 **HOD ACTION: Resolution 302 adopted as amended**

11
12 RESOLVED, That our AMA amend policy H-295.878, "Eliminating Health Disparities -
13 Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and
14 Queer (LGBTQ) Health Issues in Medical Education," by addition and deletion to read as
15 follows:

16
17 **Eliminating Health Disparities – Promoting Awareness and Education of Lesbian,**
18 **Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues, H-295.878**

19 Our AMA: (1) supports the right of medical students and residents to form groups and
20 meet on-site to further their medical education or enhance patient care without regard to
21 their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin,
22 national origin or age; (2) supports students and residents who wish to conduct on-site
23 educational seminars and workshops on health issues in Lesbian, Gay, Bisexual,
24 Transgender and Queer communities; and (3) encourages the Liaison Committee on
25 Medical Education (LCME), the American Osteopathic Association (AOA), and the
26 Accreditation Council for Graduate Medical Education (ACGME) to include Lesbian, Gay,
27 Bisexual, Transgender and Queer health issues in the basic science, clinical care, and
28 cultural competency curriculum curricula for both undergraduate and graduate medical
29 education; and (4) encourages the Liaison Committee on Medical Education (LCME),
30 American Osteopathic Association (AOA), and Accreditation Council for Graduate Medical
31 Education (ACGME) to periodically reassess the current status of curricula for medical
32 student and residency education addressing the needs of pediatric and adolescent
33 Lesbian, Gay, Bisexual, Transgender and Queer patients. (Modify Current HOD Policy)

34
35 Your Reference Committee heard unanimous testimony in overwhelming support of this
36 resolution. Additionally, there was testimony that the term "LGBTQ" may not represent
37 individuals who are "non-binary," a more prevalent term and that leaving the language
38 open to sexual orientation and gender identity may be more inclusive than the current
39 policy's specificity. The Accreditation Council for Graduate Medical Education provides a
40 model in this regard, referencing education on "sexual orientation." Your Reference
41 Committee found this language compelling and clarifying for the purpose of AMA policy
42 enhancement, and therefore has included this verbiage in its proffered revisions to
43 Resolution 302, and urges adoption as amended.

1 (8) RESOLUTION 305 – ENSURING ACCESS TO SAFE AND
2 QUALITY CARE FOR OUR VETERANS
3

4 RECOMMENDATION A:
5

6 Resolution 305 be amended by addition and deletion, to
7 read as follows:
8

9 Ensuring Access to Safe and Quality Care for our
10 Veterans H-510.986
11

12 1. Our AMA encourages all physicians to participate,
13 when needed, in the health care of veterans.
14 2. Our AMA supports providing full health benefits to
15 eligible United States Veterans to ensure that they can
16 access the Medical care they need outside the Veterans
17 Administration in a timely manner.
18

19 3. Our AMA will advocate strongly: a) that the President
20 of the United States take immediate action to provide
21 timely access to health care for eligible veterans
22 utilizing the healthcare sector outside the Veterans
23 Administration until the Veterans Administration can
24 provide health care in a timely fashion; and b) that
25 Congress act rapidly to enact a bipartisan long term
solution for timely access to entitled care for eligible
veterans.

26 4. Our AMA recommends that in order to expedite
27 access, state and local medical societies create a
28 registry of doctors offering to see our veterans and that
29 the registry be made available to the veterans in their
30 community and the local Veterans Administration.
31

32 5. Our AMA supports access to similar clinical
33 educational resources for all health care professionals
34 involved in the care of veterans such as those provided
35 by the U.S. Department of Veterans Affairs to their
36 employees with the goal of providing better care for all
veterans.

37 6. Our AMA will strongly advocate that the Veterans
38 Health Administration and Congress develop and
39 implement necessary resources, protocols, and
40 accountability to ensure the Veterans Health
41 Administration recruits, hires and retains physicians
42 and other health care professionals to deliver the safe,
43 effective and high-quality care that our veterans have
44 been promised and are owed. (Modify Current HOD
45 Policy)

46 RECOMMENDATION B:
47

48 Resolution 305 be adopted as amended.
49

50 HOD ACTION: Resolution 305 adopted as amended

1 RESOLVED, That our American Medical Association amend AMA Policy H-510.986,
2 "Ensuring Access to Care for our Veterans," by addition to read as follows:

3
4 Ensuring Access to Safe and Quality Care for our Veterans H-510.986

5 1. Our AMA encourages all physicians to participate, when needed, in the health care of
6 veterans.

7 2. Our AMA supports providing full health benefits to eligible United States Veterans to
8 ensure that they can access the Medical care they need outside the Veterans
9 Administration in a timely manner.

10 3. Our AMA will advocate strongly: a) that the President of the United States take
11 immediate action to provide timely access to health care for eligible veterans utilizing the
12 healthcare sector outside the Veterans Administration until the Veterans Administration
13 can provide health care in a timely fashion; and b) that Congress act rapidly to enact a
14 bipartisan long term solution for timely access to entitled care for eligible veterans.

15 4. Our AMA recommends that in order to expedite access, state and local medical
16 societies create a registry of doctors offering to see our veterans and that the registry be
17 made available to the veterans in their community and the local Veterans Administration.

18 5. Our AMA supports access to similar clinical educational resources for all health care
19 professionals involved in the care of veterans as those provided by the U.S. Department
20 of Veterans Affairs to their employees with the goal of providing better care for all veterans.

21 6. Our AMA will strongly advocate that the Veterans Health Administration and Congress
22 develop and implement necessary resources, protocols, and accountability to ensure the
23 Veterans Health Administration recruits, hires and retains physicians and other health care
24 professionals to deliver the safe, effective and high-quality care that our veterans have
25 been promised and are owed. (Modify Current HOD Policy)

26
27 Your Reference Committee heard strong support for the purpose and intent of Resolution
28 305. Speakers unanimously agreed that physicians should continuously strive to provide
29 optimal care for our nation's veterans. During testimony it was noted that the resolution,
30 as written, may be perceived as placing the onus of developing clinical educational
31 resources on the VA system, which has strict regulations about accessing and completing
32 required compliance and education-related training. An amendment was offered to clarify
33 the goal of developing, and making readily available, these clinical educational resources
34 which could be developed by any entity hopefully in conjunction with the VA. Speakers
35 also noted that communications between VA and non-VA communities should be
36 improved and that further policy changes related to communication merit consideration in
37 the future. Therefore, your Reference Committee recommends that Resolution 305 be
38 adopted as amended.

39
40 (9) RESOLUTION 310 – PROTECTION OF RESIDENT AND
41 FELLOW TRAINING IN THE CASE OF HOSPITAL OR
42 TRAINING PROGRAM CLOSURE

43
44 RECOMMENDATION A:

45
46 The first Resolve of Resolution 310 be amended by
47 addition and deletion, to read as follows:

1 RESOLVED, That our American Medical Association
2 study and provide recommendations on how the
3 process of assisting displaced orphaned residents and
4 fellows could be improved in the case of training
5 hospital or training program closure, including:
6 1) The current processes by which a displaced resident
7 or fellow may seek and secure an alternative training
8 position; and
9 2) How the Centers for Medicare and Medicaid Services
10 (CMS) and other additional or supplemental graduate
11 medical education (GME) funding is re-distributed,
12 including but not limited to:
13 a. The direct or indirect classification of residents and
14 fellows as financial assets and the implications thereof;
15 b. The transfer of training positions between
16 institutions and the subsequent impact on resident and
17 fellow funding lines in the event of closure;
18 c. The transfer of full versus partial funding for new
19 training positions; and
20 d. The transfer of funding for displaced orphaned
21 residents and fellows who switch specialties (Directive
22 to Take Action); and be it further

23
24 RECOMMENDATION B:
25

26 The second Resolve of Resolution 310 be amended by
27 addition and deletion, to read as follows:
28

29 RESOLVED, That our AMA work with the Centers for
30 Medicare and Medicaid Services (CMS) to establish
31 regulations that which protect residents and fellows
32 impacted by program or hospital closure, which may
33 include recommendations for:

34 1) Notice by the training hospital, intending to file for
35 bankruptcy within 30 days, to all residents and fellows
36 primarily associated with the training hospital, as well
37 as those contractually matched at that training
38 institution who may not yet have matriculated, of its
39 intention to close, along with provision of reasonable
40 and appropriate procedures to assist current and
41 matched residents and fellows to find and obtain
42 alternative training positions that which minimize
43 undue financial and professional consequences,
44 including but not limited to maintenance of specialty
45 choice, length of training, initial expected time of
46 graduation, location and reallocation of funding, and
47 coverage of tail medical malpractice insurance that
48 would have been offered had the program or hospital
49 not closed;

1 2) Revision of the current CMS guidelines that may
2 prohibit transfer of funding prior to formal financial
3 closure of a teaching institution;
4 3) Improved provisions regarding transfer of GME
5 funding for displaced residents and fellows for the
6 duration of their training in the event of program
7 closure at a training institution; and
8 4) Protections against the discrimination of displaced
9 orphaned residents and fellows consistent with H-
10 295.969 (Directive to Take Action); and be it further

11 RECOMMENDATION C:

14 The third Resolve of Resolution 310 be amended by
15 addition and deletion, to read as follows:

17 RESOLVED, That our AMA work with the Accreditation
18 Council for Graduate Medical Education, Association of
19 American Medical Colleges, National Resident
20 Matching Program, Educational Commission for
21 Foreign Medical Graduates, the Centers for Medicare
22 and Medicaid Services, and other relevant stakeholders
23 to identify a process by which displaced orphaned
24 residents and fellows may be directly represented in
25 proceedings surrounding the closure of a training
26 hospital or program (Directive to Take Action); and be
27 it further

29 RECOMMENDATION D:

31 The fourth Resolve of Resolution 310 be amended by
32 addition and deletion, to read as follows:

34 RESOLVED, That our AMA work with the Accreditation
35 Council for Graduate Medical Education, Association of
36 American Medical Colleges, National Resident
37 Matching Program, Educational Commission for
38 Foreign Medical Graduates, the Centers for Medicare
39 and Medicaid Services, and other relevant stakeholders
40 to:

41 1) Develop a stepwise algorithm for designated
42 institutional officials and program directors to assist
43 residents and fellows with finding and obtaining
44 alternative training positions; and
45 2) Create a centralized, regulated process for displaced
46 orphaned residents and fellows to obtain new training
47 positions;

1 **3) Develop pathways that ensure that closing and**
2 **accepting institutions provide liability insurance**
3 **coverage to residents, at no cost to residents.** (Directive
4 **to Take Action)**

5
6 **RECOMMENDATION E:**

7
8 **Resolution 310 be adopted as amended.**

9
10 **HOD ACTION: Resolution 310 adopted as amended, with**
11 **the following proposed fifth Resolve referred for decision:**

12
13 **RESOLVED, That our AMA urgently advocate to CMS or**
14 **other appropriate sources of funding to ensure that**
15 **liability tail coverage is provided for the 571 residents**
16 **displaced by the closure of Hahnemann University**
17 **Hospital, at no cost to the affected residents. (Directive to**
18 **take action)**

19
20 **RESOLVED, That our American Medical Association study and provide recommendations**
21 **on how the process of assisting orphaned residents and fellows could be improved in the**
22 **case of training hospital or training program closure, including:**

23 1) The current processes by which a displaced resident or fellow may seek and secure an
24 alternative training position; and
25 2) How the Centers for Medicare and Medicaid Services (CMS) and other additional or
26 supplemental GME funding is re-distributed, including but not limited to:
27 a. The direct or indirect classification of residents and fellows as financial assets and the
28 implications thereof;
29 b. The transfer of training positions between institutions and the subsequent impact on
30 resident and fellow funding lines in the event of closure;
31 c. The transfer of full versus partial funding for new training positions; and
32 d. The transfer of funding for orphaned residents and fellows who switch specialties
33 (Directive to Take Action); and be it further

34
35 **RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services**
36 **(CMS) to establish regulations which protect residents and fellows impacted by program**
37 **or hospital closure which may include recommendations for:**

38 1) Notice by the training hospital, intending to file for bankruptcy within 30 days, to all
39 residents and fellows primarily associated with the training hospital, as well as those
40 contractually matched at that training institution who may not yet have matriculated, of its
41 intention to close, along with provision of reasonable and appropriate procedures to assist
42 current and matched residents and fellows to find and obtain alternative training positions
43 which minimize undue financial and professional consequences, including but not limited
44 to maintenance of specialty choice, length of training, initial expected time of graduation,
45 location and reallocation of funding, and coverage of tail medical malpractice insurance
46 that would have been offered had the program or hospital not closed;
47 2) Revision of the current CMS guidelines that may prohibit transfer of funding prior to
48 formal financial closure of a teaching institution;

1 3) Improved provisions regarding transfer of GME funding for displaced residents and
2 fellow for the duration of their training in the event of program closure at a training
3 institution; and

4 4) Protections against the discrimination of orphaned residents and fellows consistent with
5 H-295.969 (Directive to Take Action); and be it further

6
7 RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical
8 Education, Association of American Medical Colleges, National Resident Matching
9 Program, Educational Commission for Foreign Medical Graduates, the Centers for
10 Medicare and Medicaid Services and other relevant stakeholders to identify a process by
11 which orphaned residents and fellows may be directly represented in proceedings
12 surrounding the closure of a training hospital or program (Directive to Take Action); and
13 be it further

14
15 RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical
16 Education, Association of American Medical Colleges, National Resident Matching
17 Program, Educational Commission for Foreign Medical Graduates, the Centers for
18 Medicare and Medicaid Services, and other relevant stakeholders to:

19 1) Develop a stepwise algorithm for designated institutional officials and program directors
20 to assist residents and fellows with finding and obtaining alternative training positions; and
21 2) Create a centralized, regulated process for orphaned residents and fellows to obtain
22 new training positions. (Directive to Take Action)

23
24 Your Reference Committee heard strong testimony in support of this resolution, due to the
25 recent events that occurred earlier this year at Hahnemann University Hospital in
26 Philadelphia, and the urgent need for AMA action on this issue for those individuals
27 affected and for future policies to ensure adequate protections going forward. Speakers
28 noted concerns related to the funding for residents inadvertently displaced, as might occur
29 with a natural disaster (e.g., Hurricane Katrina)—versus those who are removed from a
30 residency program due to issues with clinical performance and/or professionalism.
31 Similarly, the loss of liability coverage when a hospital goes bankrupt was a cogent
32 concern. Speakers also noted the time sensitivity associated with those residents with
33 J-1 Visa contractual obligations. To address the issue of end-to-end liability coverage for
34 residents, additional text was added to the end of Resolve 4 to ensure that neither closing
35 nor accepting institutions capitulate to financial exigencies and eliminate this needed
36 coverage. Therefore, your Reference Committee recommends that Resolution 310 be
37 adopted as amended.

1 RECOMMENDED FOR ADOPTION IN LIEU OF 2

3 (10) COUNCIL ON MEDICAL EDUCATION REPORT 2 –
4 HEALTHCARE FINANCE IN THE MEDICAL SCHOOL
5 CURRICULUM (RESOLUTION 307-A-18)

6 RESOLUTION 307 – IMPLEMENTATION OF FINANCIAL
7 EDUCATION CURRICULUM FOR MEDICAL STUDENTS
8 AND PHYSICIANS IN TRAINING

9
10 RECOMMENDATION:

11
12 Recommendation in Council on Medical Education
13 Report 2 be adopted in lieu of Resolution 307 and the
14 remainder of the report be filed.

15
16 HOD ACTION: Recommendation in Council on Medical
17 Education Report 2 adopted in lieu of Resolution 307 and
18 the remainder of the report be filed

19
20 The Council on Medical Education recommends that the following recommendation be
21 adopted in lieu of Resolution 307-A-18 and the remainder of the report be filed.

22
23 1. That our American Medical Association (AMA) amend Policy H-295.924, "Future
24 Directions for Socioeconomic Education," by addition and deletion to read as follows:

25
26 "The AMA: (1) asks medical schools and residencies to encourage that basic content
27 related to the structure and financing of the current health care system, including the
28 organization of health care delivery, modes of practice, practice settings, cost effective
29 use of diagnostic and treatment services, practice management, risk management, and
30 utilization review/quality assurance, is included in the curriculum; (2) asks medical schools
31 and residencies to ensure that content related to the environment and economics of
32 medical practice in fee-for-service, managed care and other financing systems is
33 presented in didactic sessions and reinforced during clinical experiences, in both inpatient
34 and ambulatory care settings, at educationally appropriate times during undergraduate
35 and graduate medical education; and (3) will encourage representatives to the Liaison
36 Committee on Medical Education (LCME) to ensure that survey teams pay close attention
37 during the accreditation process to the degree to which 'socioeconomic' subjects are
38 covered in the medical curriculum." (Modify Current HOD Policy)

39
40
41 RESOLVED, That our American Medical Association work with relevant stakeholders to
42 study the development of a curriculum during medical school and residency/fellowship
43 training to educate them about the financial and business aspect of medicine. (Directive
44 to Take Action)

45
46 Your Reference Committee heard testimony on Council on Medical Education Report 2 in
47 strong support of the need for adequate and appropriate education for medical students
48 and resident/fellow physicians in curricular content related to financing of the U.S. health

1 care system and personal economics. These issues are increasing in complexity, and
2 importance, and our future physicians need exposure to these issues. Similarly, testimony
3 on Resolution 307, while limited, reflected this need for targeted education on economics-
4 related issues. Curricular content on these topics is currently required by the Liaison
5 Committee on Medical Education and Accreditation Council for Graduate Medical
6 Education in undergraduate and graduate medical education, respectively. With few
7 exceptions, allopathic medical schools report the inclusion of the topics of health care
8 financing, health care costs, medical socioeconomics, and medical economics in their
9 respective curricula. Finally, our AMA provides online educational resources on health
10 systems science (HSS) topics, including the effect of payment models on health outcomes
11 and cost of care, and the AMA-supported Accelerating Change in Medical Education
12 initiative includes medical economics in the focus area of HSS. Accordingly, your
13 Reference Committee recommends that Council on Medical Education Report 2 be
14 adopted in lieu of Resolution 307.

1 RECOMMENDED FOR REFERRAL 2

3 (11) RESOLUTION 304 – ISSUES WITH THE MATCH, THE
4 NATIONAL RESIDENCY MATCHING PROGRAM (NRMP)

5 **RECOMMENDATION:**

6 **Resolution 304 be referred.**

7 **HOD ACTION: Resolution 304 referred**

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

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

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

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

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

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

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

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

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

1 Your Reference Committee heard mixed testimony in regard to Resolution 304. Online
2 and in-person testimony suggested that this resolution, which calls for a broad
3 investigation into several different aspects of the resident match, including data on
4 unmatched residents, strategies for a successful match, and last year's technological
5 failure during the SOAP process, has already been addressed in the recent past by the
6 Council on Medical Education (CME Report 6-A-17, Addressing the Increasing Number of
7 Unmatched Medical Students). Speakers noted that the AMA has extensive policy on
8 expanding graduate medical education (BOT Report, 25-A-19, All Payer Graduate Medical
9 Education Funding). Speakers also noted that the National Resident Matching Program
10 and the Association of American Medical Colleges release yearly authoritative reports on
11 match outcomes with granular data for medical students to aid in their decision making.
12 Testimony also pointed out some factual errors and erroneous statements regarding the
13 Resolves, including the incorrect name for the "National Resident Matching Program," as
14 well as a lack of awareness of the costs associated and pathways to successful
15 participation with The Match. Speakers also expressed concern that current efforts to
16 address this issue have been insufficient. Your Reference Committee initially considered
17 reaffirmation of existing policy in lieu of Resolves 1 and 2, and deletion of Resolve 3, due
18 to inconsistencies in terminology, among other issues, but we believe that referral of the
19 entire item is appropriate, so that your Council on Medical Education can fully examine
20 and address these concerns in a future study. Therefore, your Reference Committee
21 recommends that Resolution 304 be referred.

22
23 (12) RESOLUTION 309 – FOLLOW-UP ON ABNORMAL
24 MEDICAL TEST FINDINGS

25 (1)
26 **RECOMMENDATION:**

27
28 **Resolution 309 be referred.**

29
30 **HOD ACTION: Resolution 309 referred**

31
32 RESOLVED, That our American Medical Association advocate for the adoption of
33 evidence-based guidelines on the process for communication and follow-up of abnormal
34 medical test findings to promote better patient outcomes (Directive to Take Action); and
35 be it further

36
37 RESOLVED, That our AMA work with appropriate state and specialty medical societies to
38 enhance opportunities for continuing education regarding professional guidelines and
39 other clinical resources to enhance the process for communication and follow-up of
40 abnormal medical test findings to promote better patient outcomes. (Directive to Take
41 Action)

42
43 Your Reference Committee heard testimony favoring referral of Resolution 309. Speakers
44 noted that there are many different tests in different settings. Speakers also noted that
45 there is no one accepted uniform guideline for communication of abnormal test results,
46 and federal and state mandated requirements related to imaging studies vary. Speakers
47 also stressed that this item required further study to review all relevant specialties that
48 communicate patient results as well as to determine which published guidelines and
49 recommendations were evidence based. Due to the complexity of this resolution, your
50 Reference Committee recommends that Resolution 309 be referred for further study.

1 Mr. Speaker, this concludes the report of Reference Committee C. I would like to thank
2 Henry Dorkin, MD; Susan Thompson Hingle, MD; Nathaniel Nolan, MD, Venkat K. Rao,
3 MD; Abigail Solom; Daniel M. Young, MD; and all those who testified before the
4 committee, as well as our AMA staff, including Catherine Welcher, Fred Lenhoff, Tanya
5 Lopez, and Alejandro Aparicio, MD.

Henry Dorkin, MD, FAAP (Alternate)
Massachusetts

Susan Thompson Hingle, MD, MACP,
FRCP
American College of Physicians

Nathaniel Nolan, MD, MPH
American College of Physicians

Venkat K. Rao, MD, FCCP
Michigan

Abigail Solom
Minnesota

Daniel M. Young, MD, FAAFP (Alternate)
New York

Louito C. Edje, MD, MHPE, FAAFP
Ohio
Chair