AMA AMERICAN MEDICAL ASSOCIATION | MEMBERSHIP MOVES MEDICINE™

2019 RFS Interim Meeting

Marriott Marquis, San Diego
November 14-16, 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.

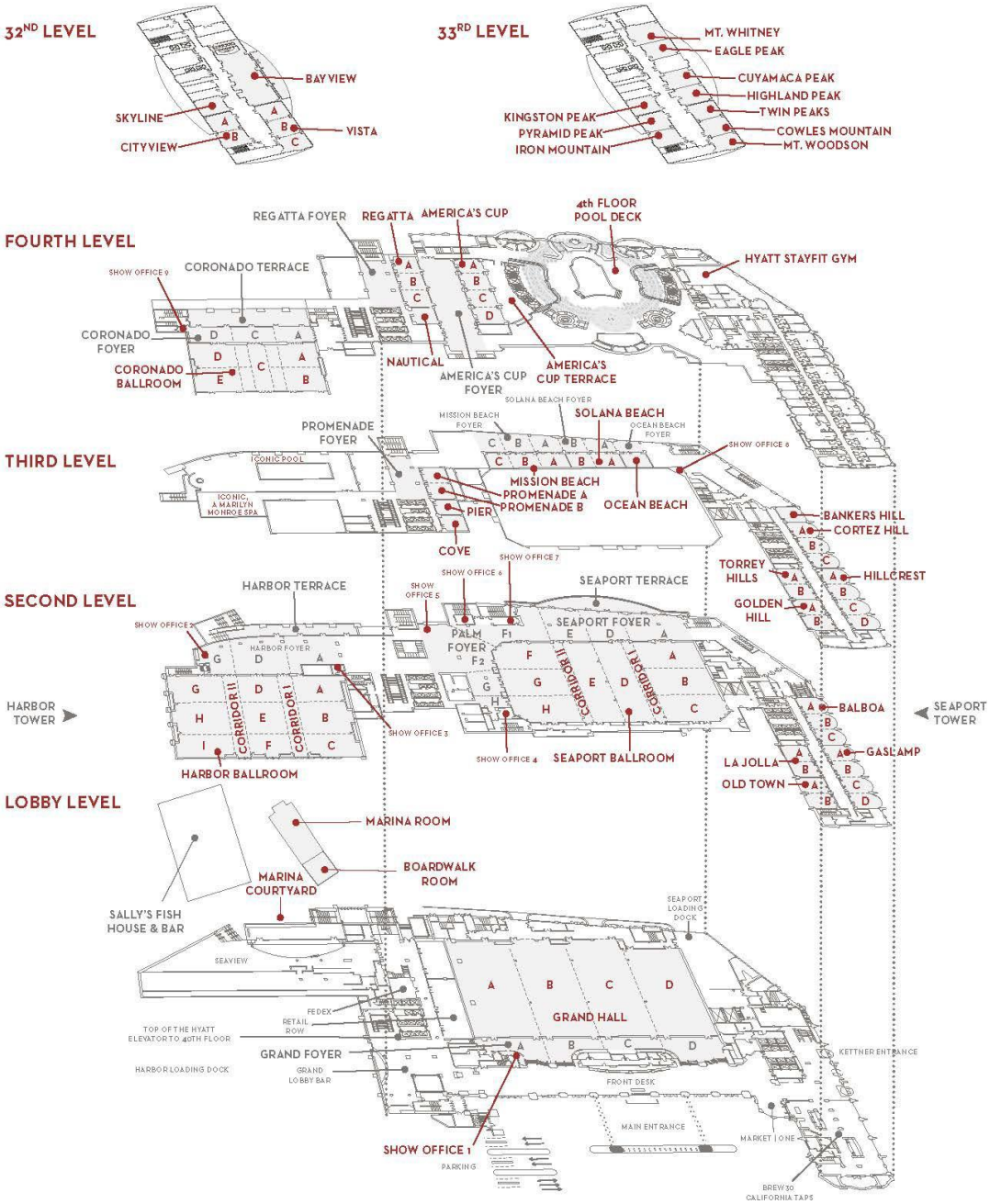
We take claims of harassment and conflicts of interest seriously. Visit **ama-assn.org/codeofconduct** to learn more. Violations of the Code of Conduct may be reported as follows:

- 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)

Manchester Grand Hyatt

FLOOR PLAN

All Floors



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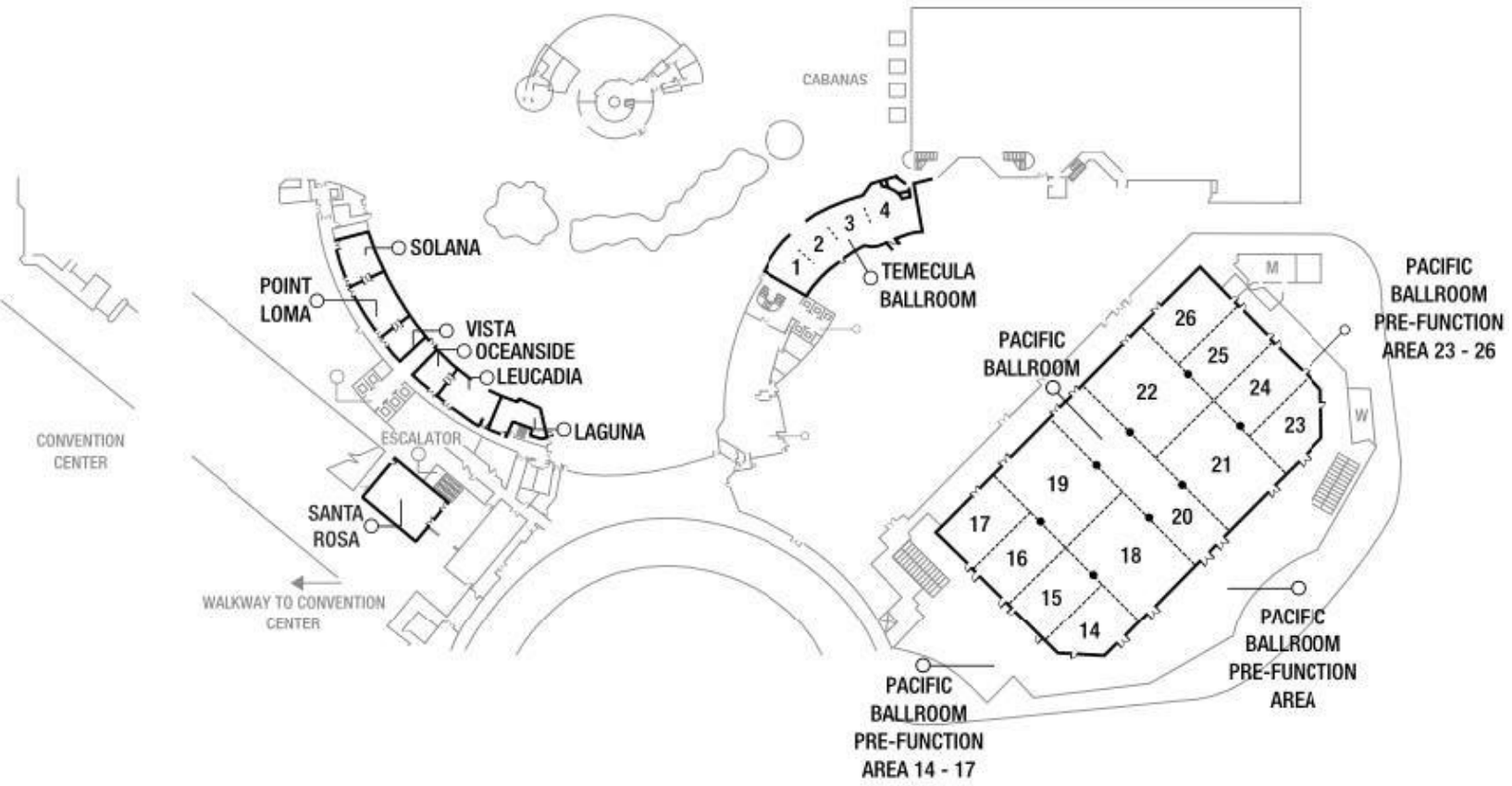
Marriott Marquis
Level One



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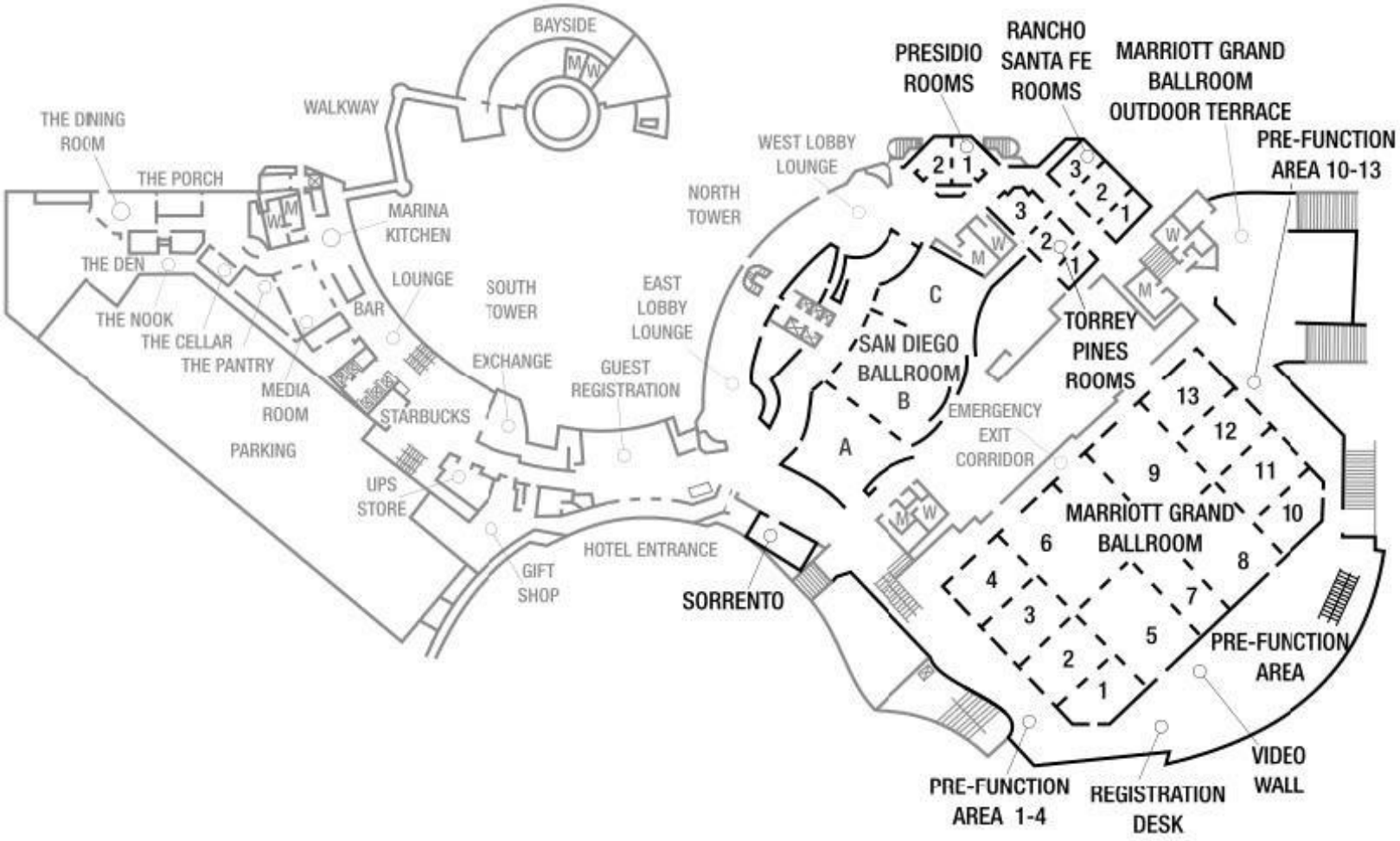
Marriott Marquis
Lobby Level



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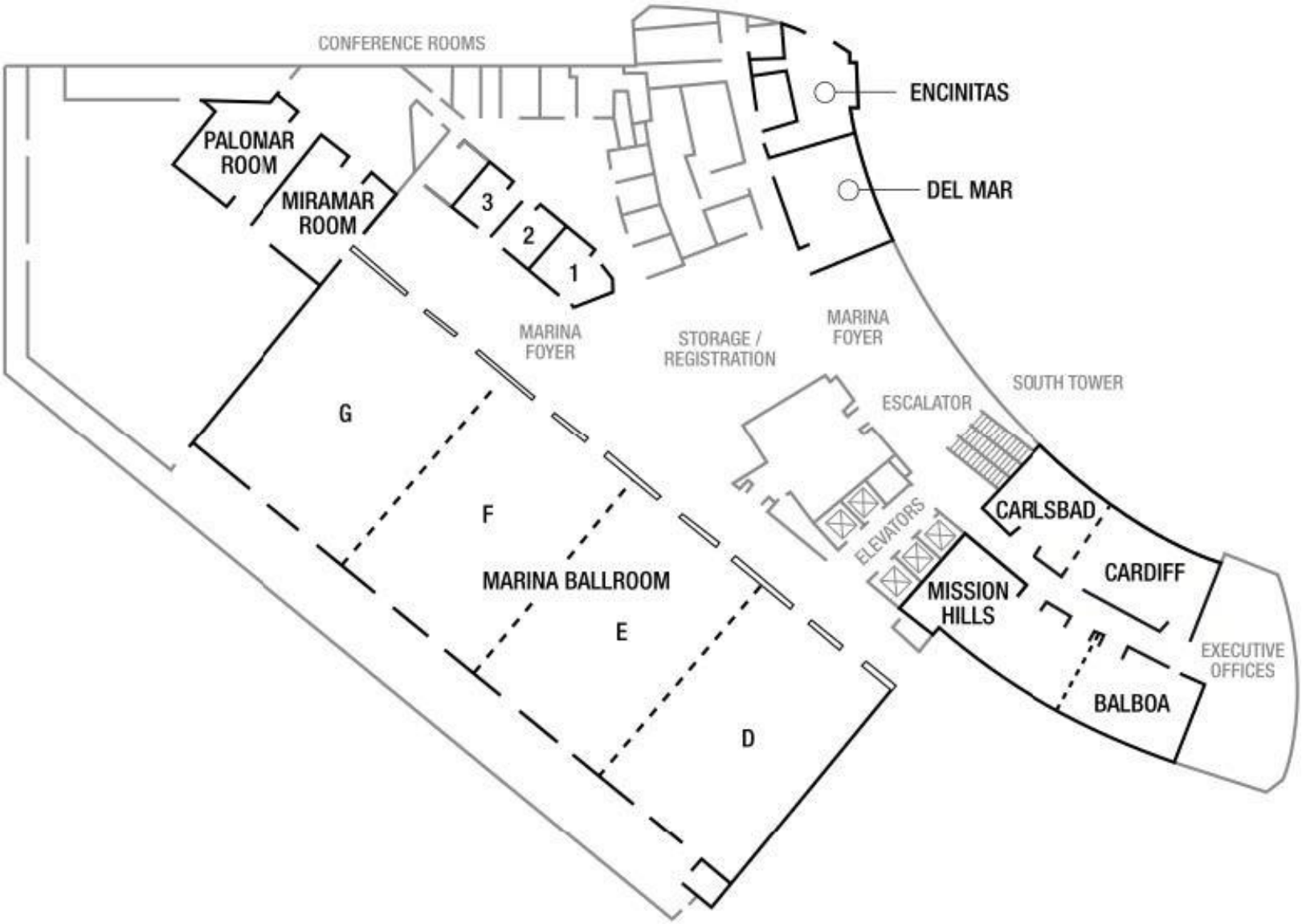
Marriott Marquis
South Tower - Level 3



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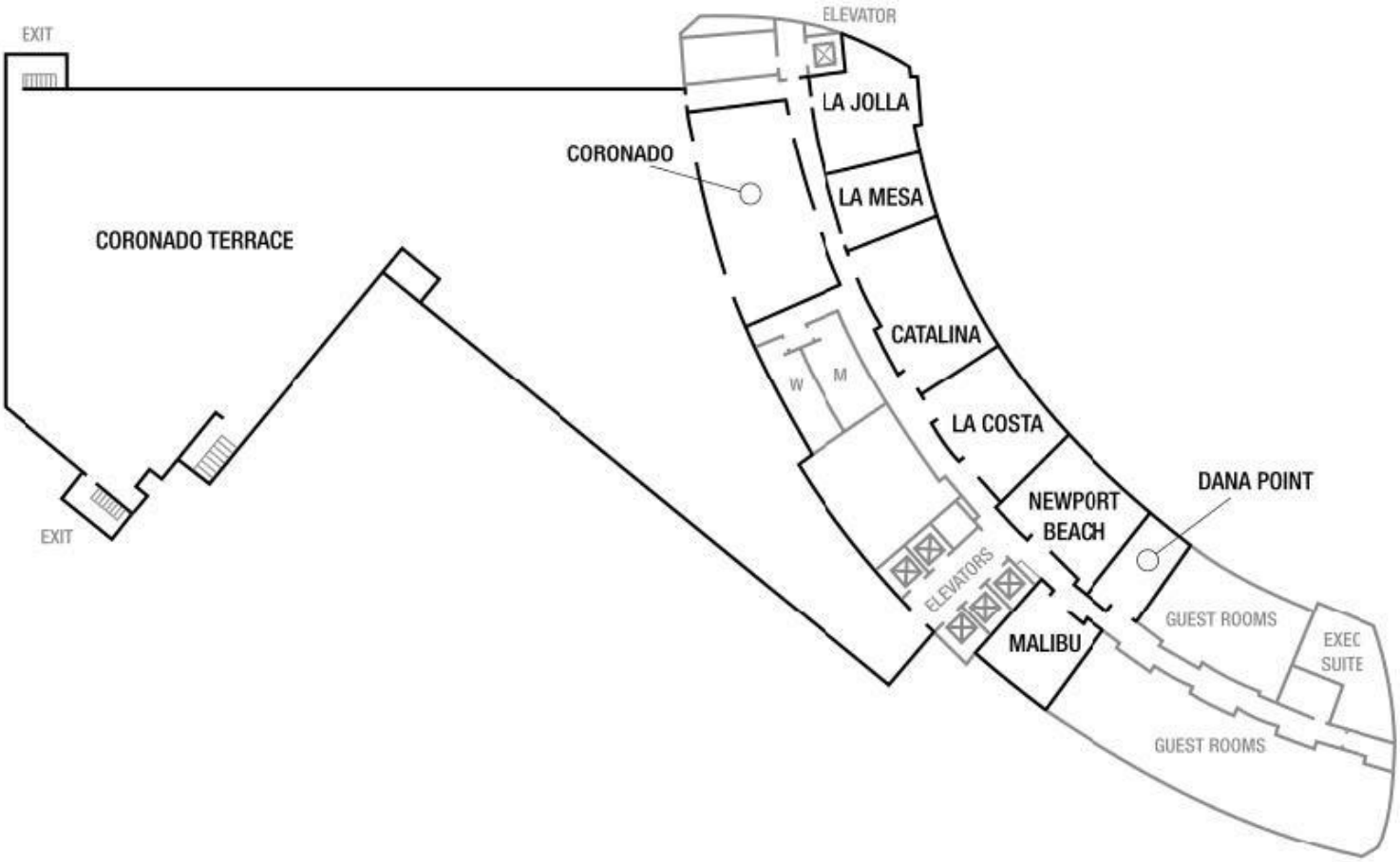
Marriott Marquis
South Tower - Level 4



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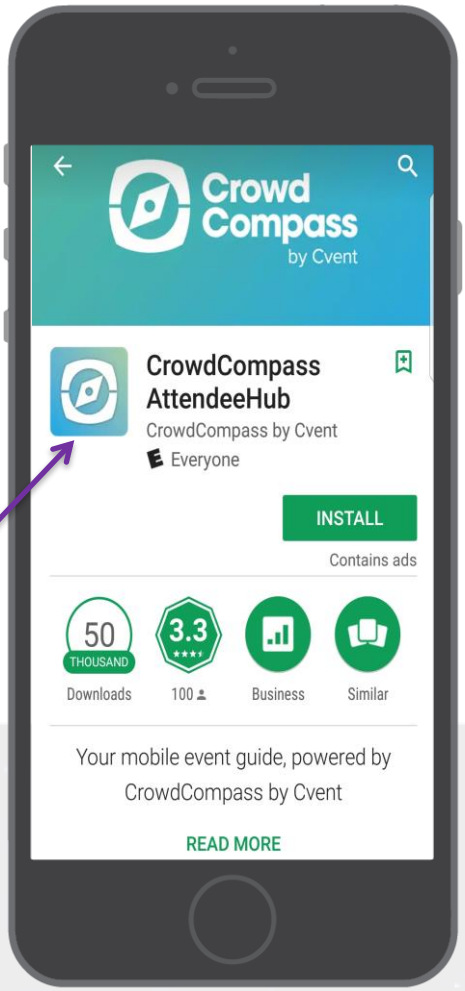
Downloading the App

Get the app

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

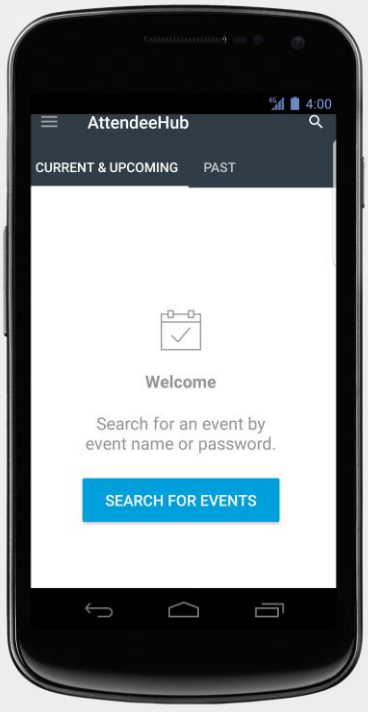
If you're using a Blackberry or Windows phone, skip these steps. **You'll need to use the web version of the app found here:**
https://event.crowdcompass.com/amainterim19

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.

AMA
AMERICAN MEDICAL ASSOCIATION

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.

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AMA Policy Development

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AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: A
(I-19)

Introduced by: RFS Delegate

Subject: Matched Medical Students

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Introduction

Since the inception of the Resident and Fellows Section (RFS) Assembly in 1978, the RFS has been driven by its mission to provide a space within the American Medical Association (AMA) for residents and fellows to advocate for policies relevant to them in their training and future practice, to network and grow as physicians, and to present an avenue for their representation in the House of Delegates (HOD) of the AMA. As part of that mission, we encourage all resident and fellow members to attend the RFS meeting.

The AMA "Constitution and Bylaws" outlines the "Definition of a Resident" and the requirements to be members of the RFS.

7.1 Resident and Fellow Section. The Resident and Fellow Section is a fixed Section.

7.1.1 Membership. All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

7.1.1.1 Definition of a Resident. For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria:

a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including underseas medical officers or flight surgeons) before their return to complete a residency.

c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

While no "Definition of a Medical Student" is provided in the AMA "Constitution and Bylaws", they are excluded from the current "Definition of a Resident" and must meet the following medical student criteria for Active Membership:

1.1.1 Active Membership.

1.1.1.1 Active Constituent. Constituent associations are recognized medical associations of states, commonwealths, districts, territories, or possessions of the United States of America. Active constituent members are members of constituent associations who are entitled to exercise the rights of membership in their constituent associations, including the right to vote and hold office, as determined by their respective constituent associations and who meet one of the following requirements:

a. Possess the United States degree of doctor of medicine (MD) or doctor of osteopathic medicine (DO), or a recognized international equivalent.
b. Are medical students in educational programs provided by a college of medicine or osteopathic medicine accredited by the Liaison Committee on Medical Education or the American Osteopathic Association leading to the MD or DO degree. This includes those students who are on an approved sabbatical, provided that the student will be in good standing upon returning from the sabbatical.

Within this category of AMA medical students, a subset has already matched to a residency program or signed a binding contract to start a residency at the time of the Annual Meeting each year. While some may still be medical students for up to 30 days after this meeting, others have already graduated, and some have already started orientation for residency.
To ease the historically difficult career transition point between medical school and residency within the AMA, Report F was approved at the 1986 Interim Meeting of the AMA-RFS, granting matched medical students the ability to participate in the meeting either as a credentialed AMA-RFS delegate to the RFS Assembly or as "Official Observers". Among the rights and responsibilities of an AMA-RFS Delegate is the ability to run for Governing Council positions. To manage the conflict that could arise from voting in two assemblies that are delineated by career timeline, the Report stipulated that these matched medical students may only credential for one assembly: the RFS Assembly or the Medical Student Section Assembly.
Previously, these allowances for matched medical students were encapsulated in both our "American Medical Association Resident and Fellow Section Internal Operating Procedures" and our "RFS Digest of Actions."

Internal Operating Procedures c. Annual 2019:
V.C.1 All members of the RFS, including fourth year medical students who have matched into a residency program, shall be eligible for election to the Governing Council.

Digest of Actions c. Annual 2019
590.011R Transition from Medical Student Section (MSS) to Resident and Fellow Section: Recommended that medical students (1) who have been accepted into residency training programs but wish to stay in MSS be awarded "Official Observer" status in the AMA-RFS; and (2) medical students accepted into a residency program beginning within six months and not registering in the MSS be allowed to credential as AMA-RFS delegates. (Report F, I-86) (Reaffirmed Report C, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

Problem
In 2018, the AMA-RFS undertook a section wide effort to update and consolidate the RFS Internal Operating Procedures (IOPs). As part of this effort, attempts were made to simplify language. One such attempt was to include matched medical students in the definition of a "Resident" for purposes of section involvement. This was done by including a change in the mission of the section:

II. Mission

B. **Mission of the RFS.** The RFS provides a direct and ongoing relationship between the AMA and residents and fellows. Specifically, the RFS:
    1. Promotes the AMA Code of Medical Ethics among residents and fellows as well as the graduate medical education community.
    2. Ensures that <u>from the Match through fellowship graduation,</u> residents and fellows are treated fairly, regardless of sex, color, creed, race, religion,

disability, ethnic origin, national origin, sexual orientation, gender identity, or age and given the full opportunity to receive graduate medical education within the policy-making structure of the AMA.
3. Debates issues and develops policy that influence the complex and rapidly changing graduate medical education environment.
4. Provides a forum to discuss timely and controversial issues, identify solutions, and cultivate relationships with residents and fellows.

By doing so, references to the exceptions for matched medical students for both election eligibility in the RFS were removed from other parts of the IOPs and the position statement 590.011R was sunset from the Digest of Actions. However, passage of updates to the RFS IOPs by the RFS Assembly are not immediately binding. Subsequent review by the AMA Council on Constitution and Bylaws, the Council on Ethical and Judicial Affairs, and the Board of Trustees determined that the "Definition of a Resident" cannot be changed in a Section's IOPs in contradiction with the AMA "Constitution and Bylaws". Therefore, this key component of the mission of the AMA-RFS was removed and the remainder of the changes were passed:

II. Mission

B. **Mission of the RFS.** The RFS provides a direct and ongoing relationship between the AMA and residents and fellows. Specifically, the RFS:
   a. Promotes the AMA Code of Medical Ethics among residents and fellows as well as the graduate medical education community.
   b. Ensures that ~~from the Match through fellowship graduation,~~ residents and fellows are treated fairly, regardless of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, or age and given the full opportunity to receive graduate medical education within the policy-making structure of the AMA.
   c. Debates issues and develops policy that influence the complex and rapidly changing graduate medical education environment.
   d. Provides a forum to discuss timely and controversial issues, identify solutions, and cultivate relationships with residents and fellows.

This currently leaves the AMA-RFS without any formal mechanism for matched medical students to become involved in the AMA-RFS at the AMA Annual Meeting despite them becoming part of the core constituency of the RFS within a matter of weeks. This was not the intention of the RFS IOP updates, nor is it in line with 33 years of RFS practices.

Solution

We discussed the option of amending the AMA "Constitution and Bylaws" "Definition of a Resident". However, this definition is used throughout the AMA Bylaws and any change might create significant off-target effects beyond our stated goal to include matched medical students at the AMA-RFS Assembly at the Annual Meeting. Instead, your AMA-RFS Governing Council recommends additional changes to our RFS IOPs to be inclusive of matched medical students within the AMA RFS and ensure our ability to continue representing these members as they transition to residency and give them opportunities to remain involved in the AMA early in their careers.

Recommendation 1:

Your AMA-RFS Governing Council recommends the following changes to the "American Medical Association Resident and Fellow Section Internal Operating Procedures" by addition as follows:

V. Elections

C. **Eligibility.** All members of the RFS are eligible for elected positions and endorsements. Medical students with AMA membership who have secured a residency position, signed a contract, and will be starting residency within 45 days of election may also be considered eligible for RFS elected positions. RFS members may not hold concurrent positions on the RFS Governing Council, Board of Trustees, or Councils with the exception of RFS Chair-Elect. All candidates must formally disclose to voters prior to the election any portion of their term during which they will not meet membership requirements.

Recommendation 2:

Your AMA-RFS Governing Council recommends the following changes to the "American Medical Association Resident and Fellow Section Internal Operating Procedures" by addition as follows:

IX. Business Meeting

A. Other Representatives to the Business Meeting.

1. At-Large Representatives. Active RFS members of the AMA may be eligible to serve as at-large representatives to the Business Meeting.
    a. Apportionment. The number of representatives shall be 10% of the average number of registered RFS delegates and alternate delegates from the previous year.
    b. Criteria for the At-Large Delegate positions include the following:
        1. A candidate must be an AMA-RFS member or a medical student with AMA membership who has secured a residency position, signed a contract, and will be starting the aforementioned residency program within 45 days of the AMA Annual Meeting, and is not simultaneously credentialed in the Medical Student Section Assembly.
        2. A candidate must submit an application to the RFS Governing Council for consideration. In the event that all available At-Large positions are not filled by application to the Governing Council, these positions may be filled at the meeting (Annual or Interim) on a first-come, first served basis.
        3.

Recommendation 3:

Your AMA-RFS Governing Council recommends the following changes to the "American Medical Association Resident and Fellow Section Internal Operating Procedures" by addition as follows:

IX. **Business Meeting**

F. Participation.

3. All medical students with AMA membership who have secured a residency position, signed a contract, and will be starting the aforementioned residency program within 45 days of the AMA Annual Meeting, and are not RFS At-Large Delegates may be granted "Official Observer" status in the RFS Assembly.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: B
(I-19)

Introduced by: RFS Delegate

Subject: AMA Resident/Fellow Councilor Term Limits

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Background

During the 1969 Presidential Address at the Clinical Convention of the American Medical Association (AMA), there was a call for, “finding ways to attract medical students, interns and residents, and other young physicians into the Association.” In response to this, the 1970 Clinical Meeting Board of Trustees (BOT) Report C designated that special delegate seats, membership category, and dues be developed for resident members. This paved the way for resident members to join AMA Councils.

At the 1975 Clinical Convention of the AMA House of Delegates, the Council on Long Range Planning and Development (CRLPD) presented Report B, titled “AMA Organizational Structure,” outlining the names and functions of eight Councils that were to be further defined by the Ad Hoc Committee on Councils and Committees. By that time, there was precedent for resident, non-voting medical student, and AMA Auxiliary representation on some Councils. Those recommendations were followed by BOT Report A at the 1976 AMA Annual Convention, which codified resident and non-voting medical student representation on the Councils with three-year term lengths and a maximum three-term limit for the Council on Medical Education (CME), Council on Medical Service (CMS), Council on Scientific Affairs, and CLRPD. Term lengths for the Council on Physical Education and Council on Legislation (COL) were one-year with a maximum nine-term limit. At that time, the Council on Constitution and Bylaws (CCB), had only a non-voting resident member appointed annually by the BOT without a specified term limit. The Judicial Council did not even specify a protected resident or medical student position and had term lengths of seven years with a one-term limit. At that time, it was specified that if a resident vacated an unexpired term, the term would be completed by another resident, selected by election or appointment based on the bylaws for each specific committee, starting at the subsequent Annual Meeting.

During the 1980 Interim Meeting of the AMA, the Council on Constitution and Bylaws Report A “Residents’ Terms on AMA Councils” further discussed resident council term lengths, recommending a mechanism for resetting the term length if a resident were to complete training with an unexpired council term because, “the resident position on AMA Councils probably has a higher incidence of unexpired terms than other members because the resident is likely to be in his/her last years of residency when elected to the Council.” However, within the report they acknowledged that there was no consensus on this, as some members of the Council felt that, “residents should not be treated differently from other members, and that the opportunity to meet the resident-candidates in more than a single election (i.e. when they run for an unexpired term) is mutually beneficial to the resident and the AMA, and assures the Association of the best people on all Councils.” Subsequently, the recommended changes were not adopted by the House of Delegates.

Starting at the 1991 Annual Meeting, AMA House of Delegates Resolution 202 “Leadership Opportunities in the American Medical Association” called for a review of the AMA Board and Councils to increase the rate of involvement of, “various demographic segments of the AMA physician population in AMA leadership.” This resolution was referred for report back and the subsequent study period yielded a survey of AMA members showing, “57% favored reducing the maximum tenure of Council members.” This led to a reduction in maximum tenure for most of the Councils being reduced to six years, not counting years serving a previously unexpired term vacated by another member. The exception to this was the Council on Ethical and Judicial Affairs (formerly the Judicial Council), which remained a single seven-year term.

During the 1996 Interim Meeting of the AMA, the Council on Long Range Planning and Development presented Report 2 “Terms of Service of AMA Councils” which discussed some of the history of Council term lengths and presented arguments for and against one-, three-, five-, and seven-year terms for AMA Councils, considering “(a) the frequency of campaigns for Council positions, (b) the responsiveness of Council members to the AMA membership, the House and the Board, (c) opportunities to replace Council members whose performance is problematic, and (d) compatibility with the maximum total number of years that individuals can serve on each Council.”

The qualitative discussion can be summarized as follows: Shorter terms would lead to increased member responsiveness and ease in removal of ineffective Council members, but increase time and cost devoted to campaigns. Shorter terms would be better suited for task-oriented Councils such as the Council on Legislation (COL). Longer terms would allow for increased evaluation time for leadership potential and reduced time and cost devoted to elections. Longer terms have the potential to reduce responsiveness to AMA membership and provide few opportunities to replace problematic Council members in or promote opportunities for new leaders. Longer terms were considered more favorable for potentially controversial Councils such as the Council on Ethical and Judicial Affairs (CEJA), allowing time for fact-finding and potentially unpopular decision-making.

Based on the concepts outlined in the body of the report, the following principles were adopted: The term of service for all Councils except COL and CEJA were changed to four-years, with a maximum total period of service of eight years. CEJA would remain one seven-year term of service. These changes excluded medical students and residents who remained on three-year terms for all Councils except for COL. COL would remain one-year terms with a maximum total period of service of eight years, including for resident and medical student members. Service on a Council as a medical student or resident would also not count towards eight-year Council service caps. The practice of filling unexpired terms was ended so all Council elections and appointments would henceforth be for full terms of service.

Following a similar timeline, the AMA invited a resident representative to the AMA BOT meetings starting in the 1970s. During the 1981 Interim Meeting of the AMA, Substitute Resolution 52 “Resident and Physician Participation and Representation in Organized Medicine” was adopted, encouraging the BOT to formally invite resident representation to BOT meetings. Following the passage of this resolution, resident members were invited to contribute to discussions, but remained non-voting members. This culminated in the BOT Report W “Resident Member of the AMA Board of Trustees” being adopted at the 1983 Annual Meeting. This allowed for the creation of a resident Trustee with a term length of two years and a maximum three-term limit. Similar to Council positions, the resident could only hold this position as long as they maintained resident membership within the AMA. Unlike some of the Council positions, the term length of the resident Trustee position has remained unchanged since its inception in 1983.

Since the inception of these positions, all “resident” Council and BOT positions have been expanded to “resident/fellow” physician members.

Per the current AMA Bylaws as of July 2019 definitions of “Resident” and “Fellow” are as follows:

7.1 Resident and Fellow Section. The Resident and Fellow Section is a fixed Section.

7.1.1 Membership. All active resident/fellow physician members of the AMA shall be members of the Resident and Fellow Section.

7.1.1.1 Definition of a Resident. For purposes of membership in the Resident and Fellow Section, the term Resident shall be applied to any physicians who meet at least one of the following criteria:

a) Members who are enrolled in a residency approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

b) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including underseas medical officers or flight surgeons) before their return to complete a residency.

c) Members who are serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency.

7.1.1.2 Definition of a Fellow. For purposes of membership in the Resident and Fellow Section, the term Fellow shall be applied to any physicians who have completed a residency and meet at least one of the following criteria:

a) Members who are serving in fellowships approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.

b) Members who are serving, as their primary occupation, in a structured clinical, educational, vocational, or research training program of at least six months to broaden competency in a specialized field.

Problem

Annually, Resident and Fellow Section (RFS) Governing Councils have developed strategic plans to help leadership improve the experience, membership, and involvement of the RFS members. Certain principles have been repeated consistently over the years, including the goal to “work to improve content at national meetings that will be relevant to members and that will engage them in the core areas of AMA involvement, Advocacy, Public Health, Community Service, Legislative Policy, Leadership Development and Membership” (2013-2016 Working Plan 550.008R). The current 2019-2020 AMA-RFS Governing Council has identified its own strategic goals, including “Increase active members and engagement of residents and fellows within the AMA” and “Support residents and fellows in their careers and organized medicine”. In evaluating prior strategic goals and those outlined by the current RFS Governing Council, it was determined that we should study the role of resident/fellow positions on AMA Councils to determine ways to increase opportunity and participation.

It was our concern that three-year resident/fellow Council positions would disproportionately inhibit members of specialties with shorter residency training periods, including Internal Medicine, Emergency Medicine, Pediatrics and Family Medicine. Based on the current election timelines, with RFS elections for endorsement to Councils in November at the Interim Meeting, and House elections in June at the Annual Meeting, residents in three-year training programs

cannot mathematically complete a full resident/fellow term on a three-year Council as they would start, earliest, in their second year of training. There are several potential adverse effects of this including limiting the potential pool of candidates for the Council positions, forcing candidates to run for positions earlier in their residency training (when clinical responsibilities are often most demanding), limiting the overall number of residents/fellows graduating the Section with Council experience, unintentionally favoring residents/fellows in longer training programs for Council positions, and longer periods of time between elections for ineffective or problematic resident/fellow Council members. The benefits with the current three-year term lengths for most Councils are primarily fewer campaigns, reduced election costs, and increased familiarity and experience in the roles and responsibilities of the Council positions.

To determine whether there was an unintentional skew in the resident/fellow representation on AMA Councils, we pooled and reviewed Council roster data from 2005-2019. In summary, a total of only five residents in three-year residencies without subsequent fellowship positions served as residents on AMA Councils over this 15-year period. Of 120 Council and BOT seats (seven Councils and BOT over 15 years), 48 seats (40.0%) were held by residents in three-year residencies, though only 13 seats (10.8%) were held by residents in three-year residencies without subsequent fellowship positions. The data collected is included in Appendix III. This is in contrast to 2019 National Resident Match Program data showing 57.0% of categorical residency positions being offered to three-year specialties.[1]

Per 2018 pooled verified GME data, the average length of residency and fellowship training is 4.6 years for AMA members and 4.9 years for non-AMA members with an average length of 4.7 years. This suggests that AMA residents and fellows are fairly representative of the larger trainee population with regards to length of training. Data was not available to differentiate resident and fellow AMA members who are active at AMA RFS meetings compared to the rest of the group, but we are concerned that there may be a selection bias based on limited opportunities that fit within the period of a three-year residency. There may be more opportunities to attract quality residents to these positions who otherwise may not have considered running with shorter term lengths. Furthermore, positions such as the resident/fellow Trustee and resident/fellow on COL have term lengths of two and one year respectively and still allow for the resident/fellow to function effectively, despite the complexities involved in both positions.

Recommendations

Based on a review of the foundational reports leading to the development of resident/fellow Council and BOT positions, the purpose of these roles is to maintain a resident voice in these bodies and to allow for residents and fellows to both gain experience in the election process and contribute meaningfully to practices of the Councils and BOT. When considering the data, we believe that residents with shorter training periods are disproportionately underrepresented in elected and appointment Council and BOT positions thus creating a disparity between primary care residents and specialty-trained ones, and furthermore creating and underrepresentation of primary care specialties in leadership positions of the AMA. We believe that reducing term lengths would help to promote the key principles outlined above, primarily expanding opportunities for resident/fellow leadership positions in these key Council and BOT roles. As such, we present the following recommendations.

Recommendation 1:

That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.5 Council on Ethical and Judicial Affairs.

6.5.7 Term.

6.5.7.2 Except as provided in Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 2~~3~~ years provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.5.8 Tenure. Members of the Council may serve only one term, except that the resident/fellow physician member shall be eligible to serve for 3 terms and the medical student member shall be eligible to serve for 2 terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of the term.

6.5.9 Vacancies.

6.5.9.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 2~~3~~-year term.

Recommendation 2:

That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.6 Council on Long Range Planning and Development.

6.6.3 Term.

6.6.3.2 Resident/Fellow Physician Member. The resident/fellow physician member of the Council shall be appointed for a term of 2~~3~~ years beginning at the conclusion of the Annual Meeting provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed except as provided in Bylaw 6.11, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.6.5 Vacancies.

6.6.5.2 Resident/Fellow Physician Member. If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 2~~3~~-year term.

Recommendation 3:

That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows:

6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.

6.9.1 Term.

6.9.1.2 Resident/Fellow Physician Member. The resident/fellow physician member of these Councils shall be elected for a term of 2~~3~~ years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant.

6.9.3 Vacancies.

6.9.3.2 Resident/Fellow Physician Member. If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the

remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 2~~3~~-year term.

[1] National Resident Matching Program (NRMP). (2019). *National Resident Matching Program Results and Data - 2019 Main Residency Match*. [online] Available at: https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/04/NRMP-Results-and-Data-2019_04112019_final.pdf [Accessed 15 Oct. 2019].

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1
(I-19)

Introduced by:	Hans Arora, Anupriya Dayal, Mark Kashtan, Ashley Lentini, Joanne Loethen, Gunjan Malhotra, Karina Sanchez, Sophia Yang, Steven Young
Subject:	Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure
Referred to:	Resident and Fellow Section Reference Committee (Sophia Yang, MD, MS, Chair)

Whereas, On June 26th, 2019, Hahnemann University Hospital in Philadelphia, Pennsylvania, announced that it would be filing for Chapter 11 bankruptcy and closing its residency programs resulting in the displacement of 571 residents and fellows from their training programs[1]; and

Whereas, The abrupt closing of Hahnemann Hospital represents the largest loss of medical trainees to a community in a single event[1,7]; and

Whereas, Another hospital, the Ohio Valley Medical Center in Wheeling, West Virginia announced on August 7, 2019 that it would be closing within 60-90 days, displacing approximately 32 internal medicine and emergency medicine residents[2]; and

Whereas, Upon closure of a Sponsoring Institution of a Graduate Medical Education (GME) program, residents and fellows previously training at that institution are given no guarantee that they will be able to secure another position to continue their medical education and training[3]; and

Whereas, While the Accreditation Council for Graduate Medical Education (ACGME) policies allow displaced residents to transfer to any hospital that is willing to train them in their specialty, such transfer is dependent on the release of the resident or fellow's training position and associated funding by the closing hospital[3]; and

Whereas, The ACGME's Institutional Requirements requires that Sponsoring Institutions of a GME training program must maintain a policy that addresses reductions in size or closure of its ACGME-accredited programs or closure of the Sponsoring Institution, though does not specify any information regarding funding or a specific timeline by which residents/fellows should be notified[4]; and

Whereas, In the event of closure/reduction in size of a GME program or closure Sponsoring Institution, medical trainees have no legal representation in the process of re-allocation of resident funding, and

Whereas, On September 5, 2019, despite the opposition of the federal government, bankruptcy court Judge Kevin Gross approved the sale by auction of Hahnemann's residency slots for $55 million to a six-hospital consortium Einstein Healthcare Network, Jefferson Health, Temple University Health System, Main Line Health, Cooper University Health Care in Camden and Christiana Care Health System in Wilmington, DE[5,6]; and

Whereas, Section 5506 of the Affordable Care Act amended the Social Security Act (SSA) by adding subsection (vi) to section 1886(h)(4)(H) "Redistribution of Residency Slots After a Hospital Closes," which among other things sets priority for hospitals seeking allocation, but does not acknowledge or address prioritization or protections for trainees[8-9]; and

Whereas, Section 1886(h)(4)(H) of the SSA has been utilized 14 times since 2010 without clear standardized guidelines addressing the prioritization and protection of trainees[10]; and

Whereas, A 2015 Government Accountability Office report found that 47% of teaching hospitals were operating their GME programs above the Medicare full-time equivalent (FTE) cap on direct GME payments, utilizing supplemental funding from state Medicaid programs, private sources, other federal bodies, or paid for directly by the institution[11]; and

Whereas, the ACGME, Association of American Medical Colleges (AAMC), National Resident Matching Program (NRMP), Educational Commission for Foreign Medical Graduates (ECFMG), and the Centers for Medicare and Medicaid Services (CMS) are each involved - be it directly or indirectly - in the process by which a displaced resident must seek an alternative training position; therefore be it

RESOLVED, That our AMA study and provide recommendations on how the process of assisting orphaned trainees could be improved in the case of training hospital or training program closure, including:

1) The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and
2) How CMS and other additional or supplemental GME funding is re-distributed, including but not limited to:
    a) the direct or indirect classification of trainees as financial assets and the implications thereof; and
    b) transfer of full versus partial funding for positions; and be it further

RESOLVED, That our AMA work with CMS to establish regulations which protect trainees impacted by program or hospital closure which may include recommendations for:

1) Notice of filing bankruptcy within 30 days to all resident and fellow trainees primarily associated with the training hospital, as well as those who contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched trainees to find and obtain alternative training positions which minimize undue financial and professional consequences including but not limited to specialty choice, length of training, location, and reallocation of funding.
2) Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution.
3) Improved provisions regarding transfer of GME funding for displaced residents for the duration of their training in the event of program closure at a training institution; and be it further

RESOLVED, That our AMA work with the ACGME, AAMC, NRMP, ECFMG, CMS, and other relevant stakeholders to identify a process by which trainees in orphaned residencies may be directly represented in proceedings surrounding the closure of a training hospital or program; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at I-19.

Fiscal Note:

Received: 9/18/19

References:

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2. Ohio Valley Medical Center Closure. ACGME News. 2019. Retrieved at: https://acgme.org/Newsroom/Newsroom-Details/ArticleID/9572/Ohio-Valley-Medical-Center-Closure
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11. U.S. Government Accountability Office. (2018, March). HHS Needs Better Information to Comprehensively Evaluate Graduate Medical Education Funding. (Publication No. GAO-18-240). Retrieved from GAO Reports Main Page via GPO Access database: https://www.gao.gov/assets/700/690581.pdf

RELEVANT RFS POSITION STATEMENT(S):

Preservation of Residency Training Positions 170.008R
That our AMA-RFS: (1) oppose the dismissal or reassignment of any current resident or fellow as a result of changes in GME funding; and (2) oppose any reduction in the number of future residency and fellowship training positions.
Citation: Res 5, I-12

Addressing the Physician Workforce Shortage by Increasing GME Funding 170.009R
That our AMA-RFS: (1) work with the AMA and in consultation with interested stakeholders to develop a comprehensive framework for a sustainable GME financing plan that addresses the physician workforce shortage and could be implemented at both the state and federal levels; and (2) work with the AMA to support pilot projects supported through state and federal funding in medically under-served areas that foster resident training programs, offer loan repayment, and support independent practice development as a means to address the physician workforce shortage.
Citation: Late Res. 1, A-13; CME Report 5, I-13

Protection Against delayed Residency Program Closure 295.002R
That our AMA: (1) encourage medical specialty boards to add delayed residency program closure to its list of exceptions to the continuity of care guidelines, expanding the definition of hardship to allow residents to transfer to another residency program for completion of board eligibility requirements, (2) encourage each Residency Review Committee to perform a timely emergency site visits to any residency program announcing delayed closure to ensure compliance with Accreditation Council for Graduate Medical Education established accreditation guidelines, and (3) encourage each Residency Review Committee to closely monitor any residency program in delayed program closure to ensure continued compliance with the Accreditation Council for Graduate Medical education guidelines and ensure appropriate sanctions are imposed, including possible immediate closure or the residency program, if

these guidelines are transgressed, and (4) that the attached AMA Policy H-310.943 Closing of Residency Programs be Reaffirmed.
Citation: Amended Res. 2, I-04; Reaffirmed Report D, I-14;

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

Catastrophic Closure of Residency Programs and Institutions 295.007R
That our AMA-RFS work with: (1) other organizations with responsibilities for graduate medical education including the Accreditation Council on Graduate Medical Education (ACGME) and its constituent Residency Review Committees, the Association of American Medical Colleges (AAMC), the American Board of Medical Specialties (ABMS), the Council of Medical Specialty Societies (CMSS), and the Graduate Medical Education Advisory Committee (GMEAC) to develop policies to facilitate placement and completion of training for residents in good standing whose program or institution closes or downsizes; and (2) specialty societies and program director organizations to identify vacant and potential residency positions for placement of displaced residents.
Citation: Substitute Res. 32, I-95; Reaffirmed Report C, I-05; Reaffirmed Report E, A-16

Displaced Residents 295.010R
That our AMA-RFS support the Accreditation Council for Graduate Medical Education (ACGME): (1) establishing guidelines for non-academic closure or downsizing of residency programs and adequate advance notification to residents wherein such guidelines could include providing residents with information, resource contacts, assistance to facilitate transfer to another accredited training program where they could complete their training, and financial assistance programs; and (2) considering waiving requirements for continuous years of training at one program and other restrictions that would otherwise significantly delay their normal tenure for completion of training in the event a resident has been subject to the closure or downsizing of his or her residency program.
Citation: Substitute Res. 2, A-94; Reaffirmed Report F, A-05; Reaffirmed Report E, A-16

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

Residency Transfers 296.002R
That the AMA-RFS: (1) continue to actively promote the resident and fellow vacancy page; (2) organize the information, including links to specialty society websites, on the resident and fellow vacancy page in a user-friendly format; (3) initiate conversation to integrate the resident and fellow vacancies into FRIEDA, a resource well known to residents and fellows, to make the information more widely distributed and easily accessible; (3) include information about procedures and logistics of transferring residency and fellowship programs or specialties.
Citation: Report E, A-17

RELEVANT AMA POLICY:

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep, 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended:

CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Res., A-19; Modified: BOT Rep. 25, A-19

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929
Citation: CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmation A-11; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13; Appended: CME 05, A-16; Appended: Res. 319, A-16; Reaffirmation A-16

Securing Funding for Graduate Medical Education H-310.917
Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.
Citation: CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12; Reaffirmed: CME Rep. 5, A-13; Appended: CME Rep. 1, I-15

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 2
(I-19)

Introduced by: Aria Razmaria, MD, MSc

Subject: Interference with Practice of Medicine by the Nuclear Regulatory Commission

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Whereas, Our AMA recently expressed its opposition to Nuclear Regulatory Commission's (NRC) imminent proposed reduction of training requirements and expansion to non-physicians pertaining to use of therapeutic radiopharmaceuticals; and

Whereas, In 1995 the National Academy of Sciences Institute of Medicine (NAS-IOM) charged and paid by NRC itself to conduct a thorough and independent external evaluation of NRC's medical use program, demonstrated significant inefficiencies and undue interference with practice of medicine by NRC[1] and provided explicit recommendations for reforms; and

Whereas, NRC's regulatory practices in the last two decades has contributed to put nuclear medicine as a specialty and its research and development in the U.S. at a disadvantage compared to many other countries in the world to the degree that some patients in need of novel nuclear medicine therapies have to travel abroad for treatment; and

Whereas, The NRC has been using rudimentary training and experience requirements to determine eligibility to practice nuclear medicine; and

Whereas, The training and experience requirement used by NRC are considerably less rigorous than the standards set forth by the American Board of Nuclear Medicine and American Board of Radiology; and

Whereas, Many hospitals and practices perceive the licensure issued by NRC as sufficient to practice all aspects of nuclear medicine and thereby the ACGME accredited dedicated nuclear medicine and radiology residency training programs are undermined in their mission and foundation; and

Whereas, Our AMA in the past repeatedly encouraged and urged NRC that comprehensive training standards in NRC's licensing procedures be maintained and that NRC's rulemaking be scientifically based and medically informed; and

Whereas, Our AMA opposes undue interference with medical practice, through governmental agencies or non-governmental entities (e.g. pharmaceutical industry or insurance companies); and

Whereas, Our AMA supports a regulatory environment that allows all medical specialties to thrive and meet the need of patients; and

Whereas, Our AMA upholds the goal of equitable and readily available access to qualified medical care; therefore be it

RESOLVED, That our AMA advocate for a follow-up review by the National Academy of Medicine, formerly Institute of Medicine, of the NRC's medical use program, specifically evaluating the adoption of the recommendations from the 1995 Institute of Medicine report and the effects of the NNRC's policies since the publication of the report on the practice of nuclear medicine in the U.S. and patients' access to care; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at I-19.

Fiscal Note:

Received: 9/20/19

References:

1. Gottfried KD, Penn G: Radiation in medicine. A need for regulatory reform. National Academy Press. Washington DC. 1996. ISBN-13: 9780309053860

RELEVANT AMA POLICY:

Interference with Practice of Medicine by the Nuclear Regulatory Commission D-455.993
Our AMA will express its opposition to the imminent proposed changes to the Section 10 CFR Part 35.390(b) by the Nuclear Regulatory Commission (NRC) which would weaken the requirements for Authorized Users of Radiopharmaceuticals (AUs), including shortening the training and experience requirements, the use of alternative pathways for AUs, and expanding the use of non-physicians, with AMA advocacy for such opposition during the open comment period ending July 3, 2019.
Citation: Res. 719, A-19

Nuclear Regulatory Commission Medical Use Program H-455.978
The AMA encourages the efforts of the Nuclear Regulatory Commission to assure that any regulations that affect the practice of nuclear medicine and radiology be science-based.
Citation: Sub. Res. 516, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Nuclear Regulatory Commission Licensure Requirements for Physicians H-455.996
Our AMA urges the U.S. Nuclear Regulatory Commission to continue to require that the training requisite for licensure be documented, and that it contain elements of instruction in radiological physics, radiation biology, radiation safety, nuclear instrumentation, and the safe and effective clinical use of radionuclides in patients.
Citation: Res. 148, A-80 Reaffirmed: CLRPD Rep. B, I-90 Modified: Sunset Report, I-00 Reaffirmed: CSAPH Rep. 1, A-10

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959:
1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.
2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:
A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.
B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.
C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be

respected by all parties.
D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter.
Citation: Res. 523, A-06; Appended: Res. 706, A-13

Government Controlled Medicine H-165.916
Our AMA strongly reaffirms its unwavering opposition against the encroachment of government in the practice of medicine as well as any attempts to covertly change the American health care system to a government program with the subsequent loss of precious personal freedoms, including the right of physicians and patients to contract privately for health care without government interference.
Citation: Res. 141, I-93; Reaffirmed: Sub. Res. 132, A-94; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation I-07; Reaffirmation A-09; Reaffirmation I-09

Government Regulations H-390.994
Our AMA vigorously opposes regulations and legislation which would: (1) interfere with and/or redefine the practice of medicine;
(2) substitute hourly wages or annual salaries for present reimbursement mechanisms for physicians' services to patients;
(3) base physician reimbursement on any system which does not give recognition to knowledge, skill, time and effort; or
(4) otherwise impinge significantly upon the practice of medicine.
Citation: (Sub. Res. 28, I-82; Amended: CLRPD Rep. A, I-92; Reaffirmed by Sub. Res. 203, A-98; Reaffirmation A-00; Reaffirmation I-01; Reaffirmed: Res. 704, A-10
Interference in the Practice of Medicine D-125.997
Our AMA shall initiate action by whatever means to bring a halt to the interference in medical practice by pharmacy benefit managers and others.
Citation: Res. 529, A-02; Reaffirmation A-10; Reaffirmed: CMS Rep. 04, A-16

Interference in the Practice of Medicine D-125.997
Our AMA shall initiate action by whatever means to bring a halt to the interference in medical practice by pharmacy benefit managers and others.
Citation: Res. 529, A-02; Reaffirmation A-10; Reaffirmed: CMS Rep. 04, A-16

AMA's Comment Letter to the U.S. Nuclear Regulatory Commission 7/1/19
https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2019-7-1-Letter-to-Svinicki-re-NRC.pdf

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 3
(I-19)

Introduced by: Chelsea Stone, DO

Subject: Required Standard of Care Stroke Assessment Training and Certification for Acute Care Hospital-Based Physicians and Out-of-Hospital Emergency Providers

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Whereas, Every year more than 795,000 people suffer a stroke resulting in 140,000 annual deaths and stroke is the leading cause of disability and healthcare expenditure in the United States[1]; and

Whereas, Early recognition and treatment of stroke can result in more effective and efficient delivery of available treatments, resulting in improved patient outcomes with fewer deaths and less disability[2,3,4,5]; and

Whereas, 6.5-15% of new strokes occur while hospitalized and are more severe and have worse outcomes than community-onset strokes and are associated with delayed symptom recognition to neuroimaging and treatment[6]; and

Whereas, Despite strong evidence[2,3,4,5] that early stroke recognition leads to better patient outcomes, there is no current mandate for standardized stroke assessment training in acute care hospital-based physicians[5,6,7,8] or out-of-hospital emergency providers; and

Whereas, Stroke certification and training, including the well-studied and validated National Institute of Health Stroke Scale (NIHSS)[9,10] would allow for a standardized method to objectively quantify the degree of stroke impairment and improve collaborative exchanges[11]; and

Whereas, Better communication would result in decreased time to treatment including medications such as alteplase[11] and/ or endovascular thrombectomy; which are shown to lessen stroke and other stroke-related complications[2,3,4,7,9]; and

Whereas, Our AMA has policy which encourages physicians to maintain and advance their clinical competence and keep up with changes in health care delivery brought about by health system reform (AMA policy H-300.958); therefore be it

RESOLVED, That our AMA advocate for greater education of stroke recognition and standard of care stroke assessment scoring for acute care hospital-based physicians, including trainees, and out-of-hospital emergency medical providers to allow for rapid diagnosis and appropriate treatment of acute ischemic stroke; and be it further

RESOLVED, That our AMA support inclusion of standard of care stroke recognition and assessment training during hospital on-boarding.

Fiscal Note:

Received: 9/20/19

References:

1. Stroke Facts. Centers for Disease Control and Prevention. https://www.cdc.gov/stroke/facts.htm. Published September 6, 2017.
2. Emberson J, Lees KR, Lyden P, et al. Effect of treatment delay, age, and stroke severity on the effects of intravenous thrombolysis with alteplase for acute ischaemic stroke: a meta-analysis of individual patient data from randomised trials. Lancet 2014;384(9958): 1929-1935. Doi:10/1016/S0140-6736(14)60584-5.
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9. Cooray C, Fekete K, Mikulik R, Lees KR, Wahlgren N, Ahmed N. Threshold for NIH stroke scale in predicting vessel occlusion and functional outcome after stroke thrombolysis. Int J Stroke 2015;10:822-829.
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11. Heikkilä I, Kuusisto H, Stolberg A, Palomäki A. Stroke thrombolysis given by emergency physicians cuts in-hospital delays significantly immediately after implementing a new treatment protocol. Scand J Trauma Resusc Emerg Med 2016 Apr 11;24:46. doi: 10.1186/s13049-016-0237-0.

RELEVANT AMA POLICY:

Support for Continuing Medical Education H-300.958
Our AMA: (1) supports the concept of lifelong learning by recognizing the importance of continuing medical education as an integral part of medical education, along with undergraduate and graduate medical education; (2) encourages physicians to maintain and advance their clinical competence and keep up with changes in health care delivery brought about by health system reform; (3) assists and supports the expansion and enhancement of funding resources for continuing medical education on a local, regional, and national basis through foundations, private industry, health care organizations and appropriate government agencies; (4) encourages U.S. medical schools to integrate continuing medical education into the continuum of undergraduate and graduate medical education;(5) supports and assists medical schools, teaching institutions, and other health-related organizations in developing and facilitating implementation of health policy that supports research in continuing medical education, relevant to the needs of practicing physicians;(6) supports efforts to facilitate and speed development of computer-based interactive and distance learning technologies to support learning needs of practicing physicians regardless of their geographic location; and (7) affirms that lifelong learning is a fundamental obligation of our profession and recognizes that lifelong learning for a physician is best achieved by ongoing participation in a program of high quality continuing medical education appropriate to that physicians medical practice as determined by the relevant specialty society.
Citation: Sub. Res. 310, A-94 Reaffirmed by CME Rep. 10, A-97 Reaffirmed: CME Rep. 2, A-07 Reaffirmed: CME Rep. 3, A-08 Appended: Res. 316, A-17

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 4
(I-19)

Introduced by: Danielle Rochlin, MD

Subject: Breast Implant-Associated Anaplastic Large Cell Lymphoma

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Whereas, In 2016, the World Health Organization provisionally classified breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) as a T-cell lymphoma[1]; and

Whereas, Policies concerning breast cancer treatment do not encompass BIA-ALCL given that this cancer is a lymphoma; and

Whereas, The 2019 National Comprehensive Cancer Care Network consensus guidelines state clearly that, "Essential to the treatment of BIA-ALCL is timely diagnosis and complete surgical excision."[2]; and

Whereas, Patients with BIA-ALCL suffer delays in care as they fight with their insurance companies to cover surgery to remove the cancer and their breast implants, as the insurance company may initially classify the surgery as cosmetic and not cover it,[3] therefore be it

RESOLVED, That our AMA support appropriate coverage of cancer diagnosis, treating surgery and other adjuvant treatment options for breast implant-associated anaplastic large cell lymphoma.

Fiscal Note:

Received: 9/16/19

References:

1. Steven H. Swerdlow, Elias Campo, Stefano A. Pileri, Nancy Lee Harris, Harald Stein, Reiner Siebert, Ranjana Advani, Michele Ghielmini, Gilles A. Salles, Andrew D. Zelenetz and Elaine S. Jaffe "The 2016 revision of the World Health Organization classification of lymphoid neoplasms, section on Mature T-cell lymphomas and NK - lymphomas." *Blood.* 2016, 127:2375-2390.
2. Mark W Clemens, MD, FACS, Eric D Jacobsen, MD, Steven M Horwitz, MD "2019 NCCN Consensus Guidelines on the Diagnosis and Treatment of Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL)." *Aesthetic Surgery Journal*. 2019, 39 (Supplement 1):S3–S13.
3. Denise Grady. A shocking diagnosis: breast implants 'gave me cancer.' *The New York Times*. 2017 May 14. Available at: https://www.nytimes.com/2017/05/14/health/breast-implants-cancer.html

RELEVANT AMA POLICY:

Breast Implants H-525.984
Our AMA: (1) supports that women be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.

Citation: CSA Rep. M, I-91Modified: Sunset Report, I-01Reaffirmed: Res. 727, I-02Modified: CSAPH Rep. 1, A-12

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 5
(I-19)

Introduced by: Danielle Rochlin, MD

Subject: Resident and Fellow Access to Fertility Preservation

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Whereas, The average age at completion of medical training in the United States is approximately 31.6 years overall[1] and 36.8 years for surgical trainees[2]; and

Whereas, Female fertility is known to decrease substantially after age 35,[3,4] with a nearly 50% drop from the early 20s to late 30s[5]; and

Whereas, Female physicians have a chance of infertility that is twice that of the general population (24.1% vs. 10.9%), with an average age at diagnosis of 33.7 years[1]; and

Whereas, The demands of residency increase the risk of pregnancy complications, with a higher rate of gestational hypertension, placental abruption, preterm labor, and intrauterine growth restriction among female residents[6–8]; and

Whereas, A majority of recent trainees perceive a stigma associated with pregnancy during training[9] and have concerns about workplace support,[10] which may deter medical students from choosing a career in a surgical or other field with longer and demanding training; and

Whereas, Approximately one third of program directors have reported discouraging pregnancy among residents in surgical training programs[10]; and

Whereas, Oocyte cryopreservation is an established method of preserving fertility[11] that can cost $10,000 per cycle, often with multiple cycles required, and $500 per year for storage,[12] in addition to requiring timely injection of ovarian stimulation medications and numerous outpatient visits for cycle monitoring and egg retrieval[13]; and

Whereas, Companies such as Google, Apple, and Facebook have been offering oocyte cryopreservation benefits to their workforce, who are similarly largely of reproductive age, for several years[14]; therefore be it

RESOLVED, That our AMA support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation; and be it further

RESOLVED, That our AMA encourage inclusion of insurance coverage for fertility preservation within health insurance benefits for residents and fellows offered through graduate medical education programs; and be it further

RESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation, including the need to attend medical visits to complete the oocyte preservation process and to administer medications in a time-sensitive fashion.

Fiscal Note:

Received: 09/19/19

References:

1. Stentz NC, Griffith KA, Perkins E, Jones RD, Jagsi R. Fertility and childbearing among American female physicians. *J Womens Health*. 2016;25(10):1059-1065.
2. Jeekel J. Crucial times for general surgery. *Ann Surg*. 1999;230(6):739.
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7. Behbehani S, Tulandi T. Obstetrical complications in pregnant medical and surgical residents. *J Obstet Gynaecol Can*. 2015;37(1):25-31.
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10. Garza RM, Weston JS, Furnas HJ. Pregnancy and the plastic surgery resident. *Plast Reconstr Surg*. 2017;139(1):245-252.
11. Practice Committees of American Society for Reproductive Medicine, Society for Assisted Reproductive Technology. Mature oocyte cryopreservation: A guideline. *Fertil Steril*. 2013;99(1):37-43.
12. Cost of Egg Freezing. USC Fertility. https://uscfertility.org/egg-freezing/cost/. Accessed June 14, 2019.
13. The Egg Freezing Process. USC Fertility. https://uscfertility.org/egg-freezing/egg-freezing-process/. Accessed June 14, 2019.
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RELEVANT RFS POSITION STATEMENT(S):

Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients 150.003R
That our AMA encourage disclosure to cancer patients on risks to fertility when gonadotoxicity due to cancer treatment is a possibility; and That our AMA support education for providers who counsel patients that may benefit from fertility preservation.
Citation: Res. 4, A-18

Oncofertility and Fertility Preservation Treatment 390.007R
That our AMA: (1) support coverage for standard fertility preservation therapy by all payers when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician; and (2) advocate for appropriate legislation requiring coverage for fertility preservation therapy services when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician.
Citation: Res. 6, A-12

Insurance Coverage for Fertility Preservations in Patients Receiving Cytotoxic or Immunomodulatory Agents 410.026R
That our AMA support payment for fertility preservation therapy services by all payers when latrogenic infertility may be caused directly or by necessary cytotoxic and/or immunomodulatory therapies as determined by a licensed physician, will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or

indirectly by necessary cytotoxic and/or immunomodulatory therapies as determined by a licensed physician.
Citation: Res. 5, A-14

RELEVANT AMA POLICY:

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967
Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.
Citation: Res. 512, A-19

Infertility and Fertility Preservation Insurance Coverage H-185.990
1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14

Infertility Benefits for Veterans H-510.984
1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 6
(I-19)

Introduced by: Christopher Wee, Courtney Harris, Hans Arora, Michael Johnson, Maria Arciniegas Calle, Laura Halpin

Subject: Establishing Minimum Standards for Parental Leave during Graduate Medical Education Training

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Whereas, A substantial number of trainees become parents during their training as a resident or fellow; and

Whereas, PGY-1 trainees will not meet eligibility for the Family Medical Leave Act, which has a 12-month employment eligibility threshold; and

Whereas, Unlike other industries, such as technology and law, "there is no standardized approach to parental leave across GME programs" [1]; and

Whereas, The Accreditation Council for Graduate Medical Education (ACGME) does not establish minimum standards for duration of parental leave for trainees; and

Whereas, A lack of minimum national standards may result in some trainees receiving substandard resources and benefits[2]; and

Whereas, Current AMA policy (H-405.960) encourages residency programs, among other stakeholders, to incorporate a "six-week minimum leave allowance;" therefore be it

RESOLVED, That our AMA petition the ACGME and the American Board of Medical Specialties (ABMS) to develop and align minimum requirements for parental leave; and be it further

RESOLVED, That our AMA petition the ACGME and the ABMS to develop pathways for trainees in good standing, who take maximum allowable parental leave, to complete their residency or fellowship training within the original time frame.

Fiscal Note:

Received: 9/20/19

References:

1. Vassallo P, Jeremiah J, Forman L, et al. Parental Leave in Graduate Medical Education: Recommendations for Reform. *Am J Med*. 2019;132(3):385-389. doi:10.1016/j.amjmed.2018.11.006
2. Baril N. Parenting during Graduate Medical Training — Practical Policy. 2019:995-997. doi:10.1056/NEJMp1902966

RELEVANT RFS POSITION STATEMENT(S):

Impact of Specialty Board Mandated Residency Completion Dates on Parental Leave During Residency 291.010R

In order to accommodate leave protected by the federal Family and Medical Leave Act (FMLA), the AMA encourage all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
Citation: Res. 2, A-09

RELEVANT AMA POLICY:

Principles for Graduate Medical Education H-310.929
Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.
(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.
Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. 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.
(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.
(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.
(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.
(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.
(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.
(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.
(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.
(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.
(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. 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 ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. 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.
(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.
(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.
(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

Citation: CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELOW SECTION

Resolution: 7
(I-19)

Introduced by: David Lee, MD

Subject: Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Whereas, Patient autonomy is one of the basic tenets of medical ethics and includes the patient's right to accept, modify, and refuse treatment[1,2]; and

Whereas, A patient desiring treatment must provide informed consent which can only be given after being informed of their diagnosis, if known, the nature and purpose of any recommended interventions, and the anticipated risks, benefits, and consequences of all options[3–5]; and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) defines informed consent as "a process of communication whereby a patient is enabled to make an informed and voluntary decision about accepting or declining medical care"[6]; and

Whereas, A patient's provider is legally and ethically obligated to inform patients as part of the consent process any party who can be reasonably anticipated to be part in their care team including but not limited to residents, nurses, students, and allied health professionals[3,7]; and

Whereas, Teaching hospitals historically used the generalized consent form as permission to perform exams of the genital areas, including for educational purposes, without deliberately informing patients of opportunities to limit how any care teams or their members could be involved in their care experience[4,8–14]; and

Whereas, In the 1980s, women vocalized demands to be asked for additional explicit consent prior to undergoing educational pelvic exams in the operating room and indicated that doing so without this consent constituted physical asssult[15]; and

Whereas, Surveys conducted in 2003 in Philadelphia and 2005 in Oklahoma found medical students were still conducting educational pelvic and rectal exams on anesthetized or unconscious patients without having obtained prior consent to do so[12,16,17]; and

Whereas, Educational pelvic exams were historically performed on patients under anesthesia in operating rooms without explicit patient consent, including by medical students not directly involved or not reasonably anticipating to be involved with the patient's ongoing care and when the patient's surgical indications did not warrant a pelvic exam[18]; and

Whereas, Varying attitudes on educating medical students on invasive exams compounded with pressures on students to achieve high academic and clinical marks may contribute to erosion of consideration for scenarios when additional patient consent is indicated[16,19–24]; and

Whereas, The Association of American Medical Colleges (AAMC) and ACOG both emphasize that pelvic exams performed under anesthesia for educational purposes should only be done with a patient's informed consent prior to conducting the exam[4,24]; and

Whereas, Various states have passed legislation outlawing educational pelvic exams and/or pelvic exams in general, potentially even when indicated as part of a procedure, on a woman who is anesthetized or unconscious without prior consent to specifically do so[14,25–32]; and

Whereas, The Joint Commission on Accreditation of Healthcare Organizations maintains that patients may decline participating in elements of clinical training programs, such as working with medical students[12,33]; and

Whereas, The AMA Code of Medical Ethics states that patient "participation in medical education is to the mutual benefit of patients and the health care system; nonetheless, patients' (or surrogates') refusal of care by a trainee should be respected in keeping with ethics guidance."[34]; and

Whereas, While patients are often open to learner involvement in their care, they may deem scrutiny of more private body parts, particularly when solely for educational purposes, to warrant specific consent beyond the level provided for general care and treatment[15,35–37]; and

Whereas, Use of professional standardized patients who teach female pelvic, male genitourinary, and rectal exams have already demonstrated significant value in medical education and further highlight the unnecessary nature of educational genital exams performed without explicit patient consent[38–40]; therefore be it

RESOLVED, That our AMA oppose performing educational pelvic, genitourinary, or rectal exams on patients under anesthesia or on unconscious patients without prior explicit informed consent to do so, and be it further

RESOLVED, That our AMA encourage institutions to review alignment of their current practices with published guidelines, recommendations, and policies with respect to informing patients about educational pelvic, genitourinary, and rectal exams performed under anesthesia or when unconscious and obtaining explicit informed consent to do so; and be it further

RESOLVED, That our AMA reaffirm policy H-320.951.

Fiscal Note:

Received: 9/20/19

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RELEVANT RFS POSITION STATEMENT(S):

Medical Student Training in Airway Management 260.014R
That our AMA recommend training in techniques and decision making in airway management of the unconscious patient for all medical students as part of their undergraduate medical education.
Citation: Substitute Res. 1, I-97; Reaffirmed Report C, I-07

Delegation of Informed Consent 340.009R
That our AMA in cooperation with other relevant stakeholders advocate that a qualified physician be able to delegate his or her duty to obtain informed consent to another provider that has knowledge of the patient, the patient's condition, and the procedures to be performed on the patient; That our AMA study the implications of the *Shinal v. Toms* ruling and its potential effects on the informed consent process.
Citation: Res. 11, I-18

RELEVANT AMA POLICY:

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

The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's

informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
(a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
(b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
(i) the diagnosis (when known);
(ii) the nature and purpose of recommended interventions;
(iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
(c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.
In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines.

2.1.6 Substitution of Surgeon
Patients are entitled to choose their own physicians, which includes being permitted to accept or refuse having an intervention performed by a substitute. A surgeon who allows a substitute to conduct a medical procedure on his or her patient without the patient's knowledge or consent risks compromising the trust-based relationship of patient and physician.

When one or more other appropriately trained health care professionals will participate in performing a surgical intervention, the surgeon has an ethical responsibility to:
(a) Notify the patient (or surrogate if the patient lacks decision-making capacity) that others will participate, including whether they will do so under the physician's personal supervision or not.
(b) Obtain the patient's or surrogate's informed consent for the intervention, in keeping with ethical and legal guidelines.

2.3.6 Surgical Co-Management
Surgical co-management refers to the practice of allotting specific responsibilities of patient care to designated clinicians. Such arrangements should be made only to ensure the highest quality of care.

When engaging in this practice, physicians should:
(a) Allocate responsibilities among physicians and other clinicians according to each individual's expertise and qualifications.
(b) Work with the patient and family to designate one physician to be responsible for ensuring that care is delivered in a coordinated and appropriate manner.
(c) Participate in the provision of care by communicating with the coordinating physician and encouraging other members of the care team to do the same.
(d) Obtain patient consent for the surgical co-management arrangement of care, including disclosing significant aspects of the arrangement such as qualifications of clinicians, services each clinician will provide, and billing arrangement.
(e) Obtain informed consent for medical services in keeping with ethics guidance, including provision of all relevant medical facts.
(f) Employ appropriate safeguards to protect patient confidentiality.
(g) Ensure that surgical co-management arrangements are in keeping with ethical and legal restrictions.
(h) Engage another caregiver based on that caregiver's skill and ability to meet the patient's needs, not in the expectation of reciprocal referrals or other self-serving reasons, in keeping with ethics guidance on consultation and referrals.
(i) Refrain from participating in unethical or illegal financial agreements, such as fee-splitting.

7.1.2 Informed Consent in Research
Informed consent is an essential safeguard in research. The obligation to obtain informed consent arises out of respect for persons and a desire to respect the autonomy of the individual deciding whether to volunteer to participate in biomedical or health research. For these reasons, no person may be used as a subject in research against his or her will.

Physicians must ensure that the participant (or legally authorized representative) has given voluntary, informed consent before enrolling a prospective participant in a research protocol. With certain exceptions, to be valid, informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision. The individual's consent must also be voluntary.

A valid consent process includes:
(a) Ascertaining that the individual has decision-making capacity.
(b) Reviewing the process and any materials to ensure that it is understandable to the study population.
(c) Disclosing:
(i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research;
(ii) any conflicts of interest relating to the research, in keeping with ethics guidance;
(iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience;
(iv) the likelihood of therapeutic or other direct benefit for the participant;
(v) that there are alternative courses of action open to the participant, including choosing standard or no treatment instead of participating in the study;
(vi) the nature of the research plan and implications for the participant;
(vii) the differences between the physician's responsibilities as a researcher and as the patient's treating physician.
(d) Answering questions the prospective participant has.
(e) Refraining from persuading the individual to enroll.
(f) Avoiding encouraging unrealistic expectations.
(g) Documenting the individual's voluntary consent to participate.
Participation in research by minors or other individuals who lack decision-making capacity is permissible in limited circumstances when:
(h) Consent is given by the individual's legally authorized representative, under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children in research.
(i) The participant gives his or her assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity.
(j) There is potential for the individual to benefit from the study.
In certain situations, with special safeguards in keeping with ethics guidance, the obligation to obtain informed consent may be waived in research on emergency interventions.

9.2.1 Medical Student Involvement in Patient Care
Having contact with patients is essential for training medical students, and both patients and the public benefit from the integrated care that is provided by health care teams that include medical students. However, the obligation to develop the next generation of physicians must be balanced against patients' freedom to choose from whom they receive treatment. All physicians share an obligation to ensure that patients are aware that medical students may participate in their care and have the opportunity to decline care from students. Attending physicians may be best suited to fulfill this obligation. Before involving medical students in a patient's care, physicians should: (a) Convey to the patient the benefits of having medical students participate in their care. (b) Inform the patients about the identity and training status of individuals involved in care. Students, their supervisors, and all health care professionals should avoid confusing terms and properly identify themselves to patients. (c) Inform the patient that trainees will participate before a procedure is undertaken when the patient will be temporarily incapacitated. (d) Discuss student involvement in care with the patient's surrogate when the patient lacks decision-making capacity. (e) Confirm that the patient is willing to permit medical students to participate in care.

9.2.2 Resident & Fellow Physicians' Involvement in Patient Care
Residents and fellows have dual roles as trainees and caregivers. Residents and fellows share responsibility with physicians involved in their training to facilitate educational and patient care goals. Residents and fellows are physicians first and foremost and should always regard the interests of patients as paramount. When they are involved in patient care, residents and fellows should: (a) Interact honestly with patients, including clearly identifying themselves as members of a team that is supervised by the attending physician and clarifying the role they will play in patient care. They should notify the attending

physician if a patient refuses care from a resident or fellow. (b) Participate fully in established mechanisms in their training programs and hospital systems for reporting and analyzing errors. They should cooperate with attending physicians in communicating errors to patients. (c) Monitor their own health and level of alertness so that these factors do not compromise their ability to care for patients safely. Residents and fellows should recognize that providing patient care beyond time permitted by their programs (for example, “moonlighting” or other activities that interfere with adequate rest during off hours) might be harmful to themselves and patients. Physicians involved in training residents and fellows should: (d) Take steps to help ensure that training programs are structured to be conducive to the learning process as well as to promote the patient’s welfare and dignity. (e) Address patient refusal of care from a resident or fellow. If after discussion, a patient does not want to participate in training, the physician may exclude residents or fellows from the patient’s care. If appropriate, the physician may transfer the patient’s care to another physician or nonteaching service or another health care facility. (f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise. (g) Observe pertinent regulations and seek consultation with appropriate institutional resources, such as an ethics committee, to resolve educational or patient care conflicts that arise in the course of training. All parties involved in such conflicts must continue to regard patient welfare as the first priority. Conflict resolution should not be punitive, but should aim at assisting residents and fellows to complete their training successfully.

9.2.5 Medical Students Practicing Clinical Skills on Fellow Students
Medical students often learn basic clinical skills by practicing on classmates, patients, or trained instructors. Unlike patients in the clinical setting, students who volunteer to act as “patients” are not seeking to benefit medically from the procedures being performed on them. Their goal is to benefit from educational instruction, yet their right to make decisions about their own bodies remains.

To protect medical students’ privacy, autonomy, and sense of propriety in the context of practicing clinical skills on fellow students, instructors should:
(a) Explain to students how the clinical skills will be performed, making certain that students are not placed in situations that violate their privacy or sense of propriety.
(b) Discuss the confidentiality, consequences, and appropriate management of a diagnostic finding.
(c) Ask students to specifically consent to clinical skills being performed by fellow students. The stringency of standards for ensuring explicit, noncoerced informed consent increases as the invasiveness and intimacy of the procedure increase.
(d) Allow students the choice of whether to participate prior to entering the classroom.
(e) Never require that students provide a reason for their unwillingness to participate.
(f) Never penalize students for refusing to participate. Instructors must refrain from evaluating students’ overall performance based on their willingness to volunteer as “patients.”
Citation: Issued 2016

AMA Opposition to "Procedure-Specific" Informed Consent H-320.951
Our AMA opposes legislative measures that would impose procedure-specific requirements for informed consent or a waiting period for any legal medical procedure.
Citation: Res. 226, A-99; Reaffirmed: Res. 703, A-00; Reaffirmed: BOT Rep. 6, A-10

Informed Consent and Decision-Making in Health Care H-140.989
(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.
(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.
(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.
(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.
(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.
(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.
Citation: BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 408, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmation A-09; Reaffirmed: BOT Rep. 05, I-16

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 8
(I-19)

Introduced by: Mark Kashtan, Daniel Liebman and Tara Shrout

Subject: Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Whereas, Americans entering the workforce currently have from one quarter to one eighth of the average job tenure as workers now aging into retirement[1]; and

Whereas, Trends such as a higher average worker education level and an increasing share of available jobs in industries with shorter-tenured careers are also contributing to increasing worker mobility, likely more so than any generational differences[1]; and

Whereas, Union membership has been in a prolonged decline, decreasing by 50% in the last 40 years, decreasing the collective bargaining power of today's workers to attain benefits such as quality health insurance[2]; and

Whereas, The number of Americans that have employer-sponsored health insurance has declined steadily over the past 20 years to 66% in 2014, with the greatest decline seen among low- and middle-income families[3]; and

Whereas, Even among those workers with employer-sponsored health insurance, as many as 25% have out-of-pocket costs so high as to be effectively uninsured[4]; and

Whereas, In addition to being increasingly inaccessible and insufficient for workers, reliance on employer-sponsored health insurance results in undesirable effects on the American worker such as "job-lock" (being unable to leave a job because of reliance on its health benefits), medical bankruptcy when a patient changes or loses their job while they or a family member requires ongoing medical treatment, and downward pressure on wages[5]; and

Whereas, The predominance of employer-sponsored insurance arose by accident out of an attempt to reduce inflation during WWII by capping wage growth with the Stabilization Act of 1942, and was never intended to become the principal form of health insurance in the United States[6]; and

Whereas, As a result of these and other trends, reliance upon a health insurance system tied to employment is becoming increasingly untenable for large portions of the United States population; therefore be it

RESOLVED, That our AMA recognizes the importance of providing avenues for affordable health insurance coverage and health care access to patients who do not have employer-sponsored health insurance, or for whom employer-sponsored health insurance does not meet their needs; and be it further

RESOLVED, That our AMA recognizes that a significant and increasing proportion of patients are unable to meet their health insurance or health care access needs through employer-sponsored health insurance, and that these patients must be considered in the course of ongoing efforts to reform the healthcare system in pursuit of universal health insurance coverage and health care access.

Fiscal Note:

Received: 9/20/19

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RELEVANT AMA POLICY:

The Future of Employer-Sponsored Insurance H-165.829
Our AMA: (1) supports requiring state and federally facilitated Small Business Health Options Program (SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP; and (2) encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges
Citation: CMS Rep. 6, I-14

Trends in Employer-Sponsored Health Insurance H-165.843
Our AMA encourages employers to:
a) promote greater individual choice and ownership of plans;
b) enhance employee education regarding how to choose health plans that meet their needs;
c) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
d) support increased fairness and uniformity in the health insurance market; and
e) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care.
Citation: CMS Rep. 4, I-07; Reaffirmed CMS Rep. 1, A-17

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 9
(I-19)

Introduced by: Christiana Shoushtari, MD, MPH and Christopher Worsham, MD

Subject: E-Cigarette and Vaping Associated Illness

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Whereas, As of October 15, 2019, there were 1,479 lung injury cases associated with the use of e-cigarettes, or vaping, products reported from 49 states (all except Alaska), the District of Columbia and one U.S. territory, as well as 33 deaths confirmed in 24 states[1]; and

Whereas, E-cigarettes are devices that produce an aerosol by heating a liquid containing various chemicals, including nicotine, flavorings, and other additives (e.g., propellants, solvents, and oils). E-liquids may also contain substances that are safe to eat but unsafe to inhale. Users inhale the aerosol, including any of these additives, into their lungs[2]; and

Whereas, Aerosols produced by e-cigarettes can contain harmful or potentially harmful substances, including heavy metals such as lead, volatile organic compounds, ultrafine particles, cancer-causing chemicals, or other agents such as chemicals used for cleaning the device[2]; and

Whereas, Preliminary reports from state health department investigations, a published case series of patients in Illinois and Wisconsin, and three other published case series, describe clinical features of pulmonary illness associated with e-cigarette product use[2,3]; and

Whereas, Currently, there is no FDA-authorized or FDA-approved electronic nicotine delivery system[4]; and

Whereas, Currently, there is no coding classification for vaping-suspected lung injury and clinicians are encouraged to report possible cases to their local or state health department for further investigation; and

Whereas, The Centers for Disease Control and Prevention (CDC) is still investigating the specific cause of these illnesses and state public health officials are to also promptly notify CDC about possible cases and refer to CDC for the most recent versions of the surveillance case definitions, reporting guidelines, and case investigation forms[1,2]; and

Whereas, The widely used International Classification of Diseases 10th Edition Clinical Modification (ICD-10-CM) does not contain any specific diagnosis codes for use or toxicity related to e-cigarettes or vaporizers, making it difficult to perform large scale epidemiological studies using clinical or insurance claims data[5]; and

Whereas, Evidence demonstrates that youth are especially attracted to flavored e-cigarette products[6]; and

Whereas, Businesses and states have taken action against e-cigarettes, such as New York, Michigan, Rhode Island and Utah states banning the sale of flavored e-cigarettes as well as Walmart and Sam's Club ending the sales of e-cigarettes[7]; and

Whereas, Juul Labs recently announced that it suspended sales of mango, crème, fruit and cucumber flavored e-cigarette pods in the United States; Mint, menthol and tobacco will continue to be sold[8,9]; therefore be it

RESOLVED, That our AMA advocate for the addition of ICD-10-CM codes to include appropriate diagnosis codes for both the use of and toxicity related to e-cigarettes and vaping, including pulmonary toxicity; and be it further

RESOLVED, That our AMA supports banning flavored e-cigarettes products; and be it further

RESOLVED, That this resolution be immediately forwarded to the House of Delegates at I-19.

Fiscal Note:

Received: 9/20/19

References:

1. Outbreak of Lung Disease Associated with E-Cigarette Use, or Vaping. Centers for Disease Control and Prevention. Accessed Oct 18 2019. https://www.cdc.gov/tobacco/basic_information/e-cigarettes/severe-lung-disease.html
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8. Juul Suspends Online Sales of Flavored E-Cigarettes. https://www.nytimes.com/2019/10/17/health/vaping-juul-e-cigarettes.html
9. E-cigarette giant Juul suspends sales of several flavored vape pods. https://www.washingtonpost.com/health/2019/10/17/e-cigarette-giant-juul-suspends-online-sales-mango-three-other-flavors/

RELEVANT RFS POSITION STATEMENT(S):

Regulation of Electronic Nicotine Delivery Systems (ENDS) 470.005R
That our AMA-RFS: (1) support taxing, labelling and regulating electronic nicotine delivery systems (ENDS) as tobacco products and drug delivery devices; (2) support legislation that restricts the minimum age, locations of permissible use, advertising, promotion, and sponsorship of ENDS to that of tobacco products; (3) support transparency and disclosure concerning design, content and emissions of ENDS; (4) recommend secure, child-proof, tamper-proof packaging and design of ENDS; (5) support enhanced labeling that warns of the potential consequences of ENDS use, restriction of ENDS marketing as tobacco cessation tools until clear evidence-based research arises suggesting the contrary, as well as

restriction of the use of characterizing flavors in ENDS; and (6) encourage basic, clinical, and epidemiological research concerning ENDS.
Citation: Res.15, A-14

RELEVANT AMA POLICY:

Electronic Cigarettes, Vaping, and Health H-495.972
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.
2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.
3. Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.
Citation: CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Modified in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed: CSAPH Rep. 03, A-19; Appended: Res. 428, A-19

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986
Our AMA:
(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
(3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores;

(c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
(9) opposes the sale of tobacco at any facility where health services are provided; and
(10) supports that the sale of tobacco products be restricted to tobacco specialty stores.
Citation: CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18

FDA Regulation of Tobacco Products H-495.988
1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G) urges Congress to pass legislation to phase in the production of reduced nicotine content tobacco products and to authorize the FDA have broad-based powers to regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products.

2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.

3. Our AMA: (A) will continue to monitor the FDA’s progress towards establishing a low nicotine product standard for tobacco products and will submit comments on the proposed rule that are in line with the current scientific evidence and (B) recognizes that rigorous and comprehensive post-market surveillance and product testing to monitor for unintended tobacco use patterns will be critical to the success of a nicotine reduction policy.
Citation: CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12; Reaffirmation A-13; Modified: Res. 402, A-13; Modified: Speakers Rep., A-14; Appended: Res. 420, A-14; Reaffirmation A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed in lieu of: Res. 412, A-19; Modified: CSAPH Rep. 03, A-19

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973
Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing

age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and (3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.
Citation: Res. 206, I-13; Modified in lieu of Res. 511, A-14; Modified in lieu of Res. 518, A-14; Modified in lieu of Res. 519, A-14; Modified in lieu of Res. 521, A-14; Modified: CSAPH Rep. 2, I-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 412, A-15; Reaffirmed in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Reaffirmation A-16; Appended: Res. 429, A-18; Modified: CSAPH Rep. 05, A-18

Legal Action to Compel FDA to Regulate E-Cigarettes D-495.992
Our AMA will consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products.
Citation: Res. 432, A-18

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 10
(I-19)

Introduced by: Sophia Spadafore, MD

Subject: Removing Sex Designation from the Public Portion of the Birth Certificate

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Whereas, Our AMA believes that the physician's nonjudgmental recognition of patients' gender identities enhances the ability to render optimal patient care (H-160.991) and opposes any efforts to deny an individual's right to determine their stated sex marker or gender identity (H-65.962); and

Whereas, The legal sex designated on the public "upper portion" of a birth certificate by a physician is typically based solely on an external evaluation and if sex cannot be determined it is left blank with no entry; sex is also not recorded on the private "lower portion" of the birth certificate where vital medical data is recorded and reported to public health officials[1-3]; and

Whereas, The certificate of live birth draws on the information contained in the medical record but is solely a legal document and is not used for patient care[3,4]; and

Whereas, Analysis of data from 1955-2000 found that up to 1.7% of births in countries including the US, Europe, and to a lesser extent Asia and Africa, deviate in some way from binary sex designation, and therefore are categorized incorrectly as male or female on their birth certificate[5]; and

Whereas, Only 9% of transgender people who want to change the sex designation on their birth certificate actually do so, and 32% of transgender people with an ID who wanted to change the sex did not do so due to cost[6-8]; and

Whereas, The National Transgender Discrimination Survey found only 24% of transgender people were able to correct the gender marker on their birth certificates,18% were denied the correction, and 53% had not attempted correction[8]; and

Whereas, A national survey of transgender individuals showed 32% of transgender people were harassed, asked to leave an establishment, or assaulted due to presenting identification that did not match their gender presentation, and 13% were denied coverage for medical services considered to be gender-specific, including routine sexual or reproductive health screenings such as Pap smears, prostate exams, and mammograms[7,8]; and

Whereas, The process of changing the sex designation on a birth certificate is complex and typically requires legal counsel, adding additional cost and a necessary education level that further disenfranchises the most vulnerable of transgender and intersex people[8]; and

Whereas, "Sexual and gender identity are characterized by fluidity and change," and individuals can and do identify as genders other than male, female, or other, and would not be aided by adding a third catch-all gender or sex category to the birth certificate[9]; and

Whereas, The German Constitutional Court recently ruled gender markers may be omitted from birth certificates in children who cannot be assigned to a binary male/female sex, and similar legislation is being considered in Malta and California[10]; therefore be it

RESOLVED, That our AMA-RFS advocate for the removal of "sex" as a designation on the public portion of the birth certificate, and that it be visible for medical and statistical use only.

Fiscal Note: Minimal

Received: 9/20/2019

References:

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RELEVANT RFS POSITION STATEMENT(S):

Removing Barriers to Care for Transgender Patients 130.005R
That our AMA (1) support public and private health insurance coverage for treatment of gender identity and (2) oppose categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician.
Citation: Res. 1, I-07

Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education 260.008R
That our AMA (1) support 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, sexual orientation, race, religion, disability, ethnic origin, national origin or age (2) support students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; (3) encourage the Liaison Committee on Medical Education (LCME) and the Accreditation Council of Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for medical education, and (4) that this resolution be forwarded to the AMA-HOD for consideration at the 2005 Annual Meeting.
Citation: Res. 5, A-05; Reaffirmed Report E, A-16; Reaffirmed Report D, I-16

Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients 300.002R
That (1) our AMA support policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician that the individual has undergone gender

transition according to applicable medical standards of care; (2) our AMA support eliminating any government requirement that an individual have undergone surgery in order to change the sex designation on birth certificates; and (3) that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventative care.
Citation: HOD Res. 004, I-13

RELEVANT AMA POLICY:

Affirming the Medical Spectrum of Gender H-65.962
Our AMA opposes any efforts to deny an individual's right to determine their stated sex marker or gender identity.
Citation: Res. 005, I-18

Medical Spectrum of Gender D-295.312
Given the medical spectrum of gender identity and sex, Our AMA: (1) Will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) Encourages members to educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; (3) Affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.
Citation: Res. 003, A-17; Modified: Res. 005, I-18

Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients H-65.967
1. Our AMA supports policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care.
2. Our AMA: (a) supports elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and supports modernizing state vital statistics statutes to ensure accurate gender markers on birth certificates; and (b) supports that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventive care.
Citation: Res. 4, A-13; Appended: BOT Rep. 26, A-14; Modified: Res. 003, A-19

Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961
Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates.
Citation: CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12

Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Our AMA will partner with public and private organizations dedicated to public health and public policy to reduce lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth suicide and improve health among LGBTQ youth.
Citation: Res. 402, A-12

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBT patients;

(iii) encouraging the development of educational programs in LGBT Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.
3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBT people.
Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

Support of Human Rights and Freedom H-65.965
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17

Access to Basic Human Services for Transgender Individuals H-65.964
Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity.
Citation: Res. 010, A-17

Appropriate Placement of Transgender Prisoners H-430.982
1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner’s genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.
2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.
Citation: BOT Rep. 24, A-18

fAMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 11
(I-19)

Introduced by:	Vamsi Aribindi, MD, Scott Leikin, MD, Romero Santiago, MD, and Daniel Udrea, MD
Subject:	Studying Physician Supervision of Allied Health Professionals Outside of Their Fields of Graduate Medical Education
Referred to:	Resident and Fellow Section Reference Committee (Sophia Yang, MD, MS, Chair)

Whereas, Advanced practice providers and allied health professionals are required under the laws of many states to be supervised to some degree by a physician; and

Whereas, News reports and articles note instances of thoracic surgeons and obstetrician/ gynecologists supervising social workers in the provision of group therapy[1] and plastic surgeons supervising physician assistants who advertise themselves as "dermatologists"[2]; and

Whereas, Widely known anecdotal evidence suggests numerous advanced practice providers practicing in various fields while being nominally supervised by physicians not trained in those fields; and

Whereas, Physicians without appropriate training supervising advanced practice providers outside of their expertise defeats the purpose of scope-of-practice laws and endangers patients; therefore be it

RESOLVED, That our AMA support a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in field which are not a core part of those physicians' completed residencies and fellowships.

Fiscal Note:

Received: 9/20/19

References:

1. Ornstein C and ProPublica. *Illinois leads Medicare billings for group therapy*. Chicago Tribune. 13 Jul 2014. https://www.chicagotribune.com/lifestyles/health/ct-medicare-group-therapy-met-20140713-story.html. Accessed 18 Sep 2019.

2. Al-agba N. *The P.A. Problem: Who You See and What You Get.* The Healthcare Blog. 24 Nov 2017. https://thehealthcareblog.com/blog/2017/11/24/the-p-a-problem/. Accessed 18 Sep 2019.

RELEVANT RFS POSITION STATEMENT(S):

Midwifery Scope of Practice and Licensure 40.001R
That our AMA develop model legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of either state nursing or medical boards; that our AMA continue to monitor state legislation activities regarding the licensure and scope of practice of midwives; and that

our AMA work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives.
Citation: Res. 5, A-08

Mid-Level Practitioner Tracking System 40.002R
That our AMA-RFS support AMA policy to promote and encourage the tracking of mid-level practitioners for the purpose of identifying underserved rural areas.
Citation: Res.?, I-94; Reaffirmed Report F, A-05; Reaffirmed Report E, A-16

RELEVANT AMA POLICY:

Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice H-360.987
Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care. (2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team. (3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team. (5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities. (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.
Citation: BOT Rep. 23, A-96; Reaffirmation A-99; Reaffirmed: Res. 240, and Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-12; Reaffirmed: BOT Rep. 16, A-13

Practice Agreements Between Physicians and Advance Practice Nurses and the Physician to Advance Practice Nurse Supervisory Ratio H-35.969
Our AMA will: (1) continue to work with the Federation in developing necessary state advocacy resource tools to assist the Federation in: (a) addressing the development of practice agreements between practicing physicians and advance practice nurses, and (b) responding to or developing state legislation or regulations governing these practice agreements, and that the AMA make these tools available on the AMA Advocacy Resource Center Web site; and (2) support the development of methodologically valid research comparing physician-APRN practice agreements and their respective effectiveness.
Citation: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 09, A-19

Physician Assistants and Nurse Practitioners H-160.947
Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician. The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):
(1) The physician is responsible for managing the health care of patients in all settings.
(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
(4) The physician is responsible for the supervision of the physician assistant in all settings.
(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.
Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Regulation of Advanced Practice Nurses H-35.964
1. AMA policy is that advanced practice registered nurses (APRNs) should be subject to the jurisdiction of state medical licensing and regulatory boards for regulation of their performance of medical acts.
2. Our AMA will develop model legislation to create a joint regulatory board composed of members of boards of medicine and nursing, with authority over APRNs.
Citation: BOT Action in response to referred for decision Amendment B-3 to Res. 233 A-17

Guidelines for Integrated Practice of Physician and Nurse Practitioner H-160.950
Our AMA endorses the following guidelines and recommends that these guidelines be considered and quoted only in their entirety when referenced in any discussion of the roles and responsibilities of nurse practitioners: (1) The physician is responsible for the supervision of nurse practitioners and other advanced practice nurses in all settings.
(2) The physician is responsible for managing the health care of patients in all practice settings.
(3) Health care services delivered in an integrated practice must be within the scope of each practitioner's professional license, as defined by state law.
(4) In an integrated practice with a nurse practitioner, the physician is responsible for supervising and coordinating care and, with the appropriate input of the nurse practitioner, ensuring the quality of health care provided to patients.
(5) The extent of involvement by the nurse practitioner in initial assessment, and implementation of treatment will depend on the complexity and acuity of the patients' condition, as determined by the supervising/collaborating physician.
(6) The role of the nurse practitioner in the delivery of care in an integrated practice should be defined through mutually agreed upon written practice protocols, job descriptions, and written contracts.
(7) These practice protocols should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patients' condition.
(8) At least one physician in the integrated practice must be immediately available at all times for supervision and consultation when needed by the nurse practitioner.
(9) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.
(10) In an integrated practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of, and respect for each other's contributions to patient care.
(11) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.
Citation: CMS Rep. 15 - I-94; BOT Rep. 6, A-95; Reaffirmed: Res. 240, A-00; Reaffirmation A-00; Reaffirmed: BOT Rep. 28, A-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 12
(I-19)

Introduced by: Nikesh Bajaj, DO

Subject: Updating Current Wellness Policies and Improving Implementation

Referred to: Resident and Fellow Section Reference Committee
(Sophia Yang, MD, MS, Chair)

Whereas, Previous AMA-RFS policy asked our AMA to study resident burnout prevention and wellness strategies (291.015R); and

Whereas, This same policy was reaffirmed at I-18 (291.036R); and

Whereas, Current Accreditation Council for Graduate Medical Education (ACGME) policy does include program requirements for specific aspects, but is unclear about what satisfies those requirements[1]; and

Whereas, New data exists regarding the efficacy of various specific burnout prevention strategies[2-7]; and

Whereas, Some organizations such as Stanford Medicine have been leaders in the field of physician wellness and burnout prevention through research, novel approaches and curriculum and support such as House Staff Wellbeing Panel and it may be prudent to apply these strategies into ACGME common requirements of residency programs[8]; and

Whereas, These specific strategies may be a more effective way to mitigate burnout than the current ACGME policy as listed; therefore be it

RESOLVED, that our AMA work in conjunction with ACGME to review recent data supporting burnout prevention and mitigation strategies and work with ACGME in the amendment of the current Common Program Requirements policy to more specifically define wellness strategies and support implementation of these data-supported burnout prevention and mitigation strategies.

Fiscal Note:

Received: 9/20/19

References:

1. "Common Program Requirements." *ACGME*, Accreditation Council for Graduate Medical Education, https://www.acgme.org/What-We-Do/Accreditation/Common-Program-Requirements.
2. Mindfulness therapies on health professionals. Ruiz-Fernández MD, Ortíz-Amo R, Ortega-Galán ÁM, Ibáñez-Masero O, Rodríguez-Salvador MDM, Ramos-Pichardo JD. Int J Ment Health Nurs. 2019 Sep 9. doi: 10.1111/inm.12652. [Epub ahead of print] Review. PMID: 31498549
3. Gazelle G, Liebschutz JM, Riess H. Physician burnout: coaching a way out. *J Gen Intern Med*. 2015;30(4):508–513. doi:10.1007/s11606-014-3144-y

4. Doctor, how can we help you? Qualitative interview study to identify key interventions to target burnout in hospital doctors. Walsh G, Hayes B, Freeney Y, McArdle S. BMJ Open. 2019 Sep 5;9(9):e030209. doi: 10.1136/bmjopen-2019-030209. PMID: 31492785
5. Interventions to increase resilience in physicians: A structured literature review. Moorfield C, Cope V. Explore (NY). 2019 Aug 12. pii: S1550-8307(19)30448-3. doi: 10.1016/j.explore.2019.08.005. [Epub ahead of print] Review. PMID: 31492550
6. What Is Underlying Resident Burnout in Urology and What Can Be Done to Address this? Fainberg J, Lee RK. Curr Urol Rep. 2019 Sep 2;20(10):62. doi: 10.1007/s11934-019-0925-1. Review. PMID: 31478112
7. The effects of playing music on mental health outcomes. Wesseldijk LW, Ullén F, Mosing MA. Sci Rep. 2019 Aug 30;9(1):12606. doi: 10.1038/s41598-019-49099-9. PMID: 31471550
8. https://wellmd.stanford.edu/

RELEVANT RFS POSITION STATEMENT(S):

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

Strategies to Reduce Burnout in Medical Trainees 291.036R
That AMA-RFS policy Intern and Resident Burnout 291.015R be reaffirmed.
Citation: Resolution 8, I-18

RELEVANT AMA POLICY:

Code of Medical Ethics
9.3.1 Physician Health & Wellness
When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.
To fulfill this responsibility individually, physicians should:
(a) Maintain their own health and wellness by:
(i) following healthy lifestyle habits;
(ii) ensuring that they have a personal physician whose objectivity is not compromised.
(b) Take appropriate action when their health or wellness is compromised, including:
(i) engaging in honest assessment of their ability to continue practicing safely;
(ii) taking measures to mitigate the problem;
(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;
(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.
Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.
Citation: Issued: 2016

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow,

and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.
Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Informational Report: 1
(I-19)

Introduced by: AMA-RFS Governing Council
Tani Malhotra, MD, Chair

Subject: AMA-RFS Organizational Report

The AMA-RFS is the largest organization of resident and fellow physicians in the United States. It was created by the AMA in 1974 to represent and advocate for resident and fellow physicians and to train young physician leaders. With the support of members, your Resident and Fellow Section fights to improve working conditions, reform America's health care system, improve medical education, and create tools to help resident and fellow physicians succeed both personally and professionally.

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

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

Leadership Opportunities

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

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

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

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

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

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

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

Involvement

Become an AMA Ambassador

AMA Ambassadors are our strongest supporters, reinforcing that physician members are the driving force behind the AMA's work. They represent the AMA in their communities and raise awareness about AMA results, initiatives and the value of membership. By supporting the AMA and encouraging peers to support us too, they are continually sharing how Membership Moves Medicine. Become an AMA Ambassador

Doctors Back to School program

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

AMPAC Campaign School

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

Resources

The following are some of the many resources and benefits available to you as one of more than 50,000 members of the AMA-RFS:

FREIDA™, the AMA Residency & Fellowship Database®

FREIDA™, the AMA Residency & Fellowship Database® allows you to search for a residency or fellowship from more than 11,000 programs - all accredited by the Accreditation Council for Graduate Medical Education (ACGME).

Health Workforce Mapper

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

JAMA CareerCenter®

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

Transition to Practice

Access resources to prepare you for the transition from training to practice, including practice setting options, contract negotiation, navigating state medical licensure and much more!

AMA Publications and Newsletters
Access a variety of journals and newsletters to stay current on the most pressing issues facing physicians.

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

Member benefit plus
Get AMA negotiated discounts on products and services. Check back on occasions since the AMA is continuing to expand these offerings.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Informational Report: 2
(I-19)

Introduced by: AMA-RFS Governing Council
Tani Malhotra, MD, Chair

Subject: Advocacy Highlights

Advocacy Structure	
Government Affairs	•Lobbies Congress to pass/defeat legislation based on AMA policy priorities •Advocates to the Administration/federal agencies on regulatory issues •Prepares testimony, comment letters, fact sheets •Assists other AMA Business Units with federal issues •Staffs Council on Legislation which advises the Board on legislative issues
Political Affairs	•Runs AMA grassroots programs (Patients Action Network - 1.4 million members), (Physician Grassroots Network - 35,000 members) and the Very Influential Physicians (VIP) program •Manages issue advocacy campaigns and grassroots microsites •AMPAC donates to candidates for the U.S. House of Representatives and Senate who are aligned with the AMA's legislative priorities
Advocacy Resource Center	•AMA State government affairs unit •Works closely with state medical associations and national medical specialty societies to advance AMA policy at state level •Drafts state model bills, talking points, etc. •Advocates to national policy making groups that represent governors, legislators, insurance commissioners •Hosts the State Advocacy Summit in January
Health Policy	•Develops AMA policy reports/recommendations through the Council on Medical Service •Conducts economic analyses in direct support of AMA advocacy priorities •Manages the RUC which makes recommendations to CMS on Medicare payment

	•Leads AMA efforts to reduce practice burdens/ promote administrative simplification for physician practices, such as prior authorization
Advocacy Operations/Federation Relations	•Federation Relations staff are the main points of contact for the Federation (which includes national, state and county medical societies) •Hosts the National Advocacy Conference each February in Washington DC – over 500 attendees •Advocacy communications staff help publicize AMA legislative and regulatory accomplishments

Top Issues in 2019

- **Drug pricing** – The cost of prescription drugs is a major problem. We want greater transparency so we can target legislative fixes to address skyrocketing prices. In 2019, we will continue the TruthinRx.org campaign with heightened grassroots mobilization efforts and pursue drug pricing legislation that reflects AMA advocacy objectives.
- **Access to Care** – The uninsured live sicker and die younger. We want to build on the ACA to expand care to affordable/meaningful coverage for all. In 2019, we will continue to promote Medicaid expansion and advocate for policies that stabilize the individual insurance market.
- **Gun Violence** – We need stronger background checks and more research money. In 2019, we will urge federal and state policymakers to fund research on prevention of gun violence and strengthen background checks and other measures to prevent deaths and injuries from firearms.
- **Opioids** – We urge physicians to follow best practices and are pushing insurers to provide better access to medication assisted treatment. In 2019, we will continue to advocate for increased funding for multidisciplinary pain care and treatment for substance use disorders, as well as increased enforcement of mental health parity laws.
- **Prior authorization** – this hinders patient care and adds to physician administrative hassle. We want insurers to develop better internal practices, but we are pushing legislative fixes too. In 2019, we will work to reduce both the overall volume of prior authorization requirements and the number of physicians subjected to such requirements.
- **Regulatory Relief** – We are working to eliminate, streamline, align and simplify the many federal rules and regulations imposed on physicians.
- **Payment Reform** – We continue to advocate to the Centers for Medicare & Medicaid Services and Congress for continued improvements to the Quality Payment Program.
- **Insurance reform** – Advocate directly with health insurers to stop policies that adversely affect patients and physicians.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Informational Report: 3
(I-19)

Introduced by: AMA-RFS Governing Council
Tani Malhotra, MD, Chair

Subject: Fiscal Affairs

The American Medical Association Resident and Fellow Section (AMA-RFS) Governing Council provides a fiscal affairs report to the Assembly at each Annual Meeting. The preparation of this report is in response to AMA-RFS Resolution 18 (A78), reaffirmed at the 1998 and 2008 Interim Meetings. This report is presented for the information of the Assembly.

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

The RFS budget is divided into five program budgets: Assembly Meetings, Governing Council, Research Symposium, Grants, and Staff. The total AMA-RFS operating budget is approximately $285,916 for 2019.

The total program budget for the RFS Governing Council and Assembly is $167,066 (not including staff compensation costs). This is approximately 58% of the budget and provides for the meeting expenses of the two Assembly meetings and three Governing Council meetings. The Research Symposium budget is $101,750 which is approximately 38% of the budget. Expenses covered include meeting room rental, equipment such as audio-visual, production of meeting material, postage and freight for meeting materials, supplies, travel, lodging, meals and speakers.

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

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Informational Report: 4
(I-19)

Introduced by: RFS Delegate

Subject: Sunset Mechanism

At the 1985 Interim Meeting, the American Medical Association-Resident and Fellow Section (AMA-RFS) Assembly adopted a report entitled, “Sunset of AMA-RFS Policy.” This report established a mechanism to systematically review AMA-RFS actions ten years after their adoption and identify and rescind outmoded, irrelevant, duplicative, or inconsistent actions. These actions are and will continue to be catalogued in the AMA-RFS “Digest of Actions”. As of A-19, the amended IOPs specify that an informational report be prepared for review at the Interim Meeting, with final recommendations to be considered for action at the Annual Meeting.

Due to a change in standards of nomenclature in the updated IOPs, all resolutions archived in the Digest of Actions shall state “Our AMA-RFS” and shall henceforth be referred to as “internal position statements.” The appendix of this report contains a list of recommended actions regarding internal position statements last reviewed from the RFS 2008-2010 fiscal years, as well as other relevant or associated outdated positions. Positions considered outmoded, irrelevant, duplicative and inconsistent with more current positions will have specific recommendations. For each internal position statement under review, this sunset report recommends to: (1) rescind, (2) reaffirm, (3) reconcile with more recent actions, or (4) reaffirm with editorial changes, which constitutes a first order motion. A succinct justification for each recommendation will be provided. Due to the IOP change, all existing statements not up for review on the sunset calendar, or that do not require reconciliation, will be updated with editorial changes in the Digest of Actions, but will not be reset on the sunset calendar and are not included in the appendix of this report.

Each individual item may be extracted from the report to be discussed by the General Assembly, but only in the frame of adopting or not adopting the original recommendation as additional amendments will not be allowed from the floor. Any action that retains or updates an item resets the sunset timeline. Defeated sunset recommendations extend the item for one year, to be reconsidered in the next academic year. This information is presented to the Assembly at this November 2019 Interim Meeting in the form of an informational report to allow ample time for delegates to consider these initial recommendations. In order for the sunset mechanism to operate efficiently, it is important that each representative review the report now.

If a delegate disagrees with the recommendation, that delegate will have sufficient time between reading the informational sunset report which is presented to the Assembly and the final report to draft a new resolution. This allows time for new resolutions to be submitted this meeting to compensate for well-intentioned actions that should be rescinded because they are outmoded. Any new resolution must stand on its own independent of the sunset report.

APPENDIX I
RECOMMENDED ACTIONS ON 2008-2010 RFS POSITIONS

Policy No.	Title	Text	Recommendation
10.002R	Amending Child Restraints Laws	That our AMA-RFS support federal legislation that increases law enforcement standards for child safety seat use in the U.S. and support state and federal legislation that updates child car seat violations from a secondary to a primary law. (Resolution 4, A-07)	Reaffirm with editorial changes.
20.001R	Global HIV/AIDS Prevention	That our AMA-RFS: (1) support continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives, or grantee pledges of opposition to prostitution, and (2), support ~~extend its support of~~ comprehensive family-life education to foreign aid programs, promoting abstinence as the best method to prevent sexually-transmitted disease transmission while ~~but~~ also discussing the role of condoms in disease prevention. (Late Resolution 5, A-08)	Reaffirm with editorial changes.
20.002R	Support of a National HIV/AIDS Strategy	That our AMA–RFS support the concept of a national HIV/AIDS strategy and that our AMA-RFS support the following guiding principles ~~as outlined by the Coalition for a National AIDS Strategy~~: (a) Improve prevention, care, and treatment outcomes through reliance on evidence-based programming; (b) Set ambitious and credible prevention, care, and treatment targets and require annual reporting on progress toward goals; (c) Identify clear priorities for action across federal agencies and assign responsibilities, timelines, and follow-through; (d) Include, as a primary focus, the prevention and treatment needs of African Americans and other communities of color, women of color, men who have sex with men (MSM) of all races and ethnicities, and other groups at elevated risk for HIV; (e) Address social, economic, and structural factors that increase vulnerability to HIV infection; (f) Promote a strengthened and more highly coordinated HIV prevention and treatment research effort; ~~and~~ (g) Involve many sectors in developing the	Reconcile – The "Coalition for a National AIDS Strategy" is not commonly referenced in modern AIDS planning nor is this strategy easily searchable. The remainder of the policy is still valuable to retain for its guiding principles.

		Strategy, including government, business, community, civil rights organizations, faith-based groups, researchers, and people living with HIV/AIDS~~. The resolution also asks that the AMA to~~ ; (h) W~~w~~ork with the White House Office of National AIDS Policy, the Department of Health and Human Services Office of HIV/AIDS Policy, and other relevant bodies to develop, enact, and maintain a national HIV/AIDS strategy. (Resolution 4, A-09)	
20.003R	Review of AMA Policy on HIV-Infected Physicians	That our AMA-RFS strongly support proposed changes in the Council on Ethical and Judicial Affairs (CEJA) Opinion 4-A-99, *Physicians and Infectious Diseases and CEJA* and Opinion 5-A-99*, HIV-Infected Patients and Physicians*, which change the terminology regarding the level of risk of physician-to-patient transmission of bloodborne infections appropriate for restricting a physician's medical practice from "identified risk" to "significant risk". (Substitute Resolution 3, A-99) (Reaffirmed Report C, I-09)	Rescind – These changes have been made so this is now outdated policy.
20.004R	Bloodborne Pathogen Chemoprophylaxis for Medical Students and Residents	That (1) our AMA encourage OSHA to make the prophylaxis standard for HIV equivalent to that of HBV, (2) our AMA encourage the FDA to label saquinavir mesylate, ritonavir, nelfinavir, and indinavir sulfate which are currently labeled for HIV treatment, for HIV prophylaxis, and (3) our AMA-RFS ask the Liaison Committee for Medical Education to survey medical schools on their policies regarding chemoprophylactic treatment of students in the event of a possible exposure to a blood borne pathogen and report back to the RFS and the Medical Student Section. (Report L, A-97)(Reaffirmed Report D, I-16)	Rescind - This policy references out-of-date laws and practices. Generic policy supporting chemoprophylaxis for trainees could be useful for an internal position in a future resolution.
30.001R	Alcohol and Youth	That our AMA-RFS support: (1) ~~encourage~~ state medical societies ~~to~~ working with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol and (2) working with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents. (Substitute Resolution 9, A-01) [HOD Resolution 415, I-01]	Reaffirm with editorial changes.

40.001R	Midwifery Scope of Practice and Licensure	That our AMA-RFS support: (1) the development of model legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of either state nursing or medical boards; (2) ~~that our AMA continue to~~ monitor state legislation activities regarding the licensure and scope of practice of midwives; and (3) ~~and~~ that our AMA work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives. (Resolution 5, A-08)	Reaffirm with editorial changes.
40.002R	Mid-Level Practitioner Monitoring~~Tracking System~~	That our AMA-RFS support ~~AMA policy to promote and encourage~~ the tracking of mid-level practitioners for the purpose of identifying and defining their role in underserved rural communities~~areas~~. (Resolution, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reconcile - Changes made to clarify and simplify the intent of the original resolution as it is still relevant.
50.001R	Pediatric Suspected Intentional Trauma	That our AMA-RFS: (1) support comprehensive reporting and investigation of all cases of reasonably suspected child abuse and neglect using an inclusive and interdisciplinary method in accordance with state and federal laws; and (2) support the creation of a national standardized pediatric intentional trauma curriculum for medical students and residents. (Resolution 3, A-07)	Reaffirm with editorial changes.
50.002R	Home Sedation for Children Undergoing Outpatient Procedures	~~Recommended that a resolution be forwarded to the AMA-HOD at I-06 with the following resolved clauses:~~ That our AMA-RFS ~~study and examine the issue of sedating children outside of a monitored healthcare setting, and report back at the 2007 Annual Meeting; That our AMA work with interested specialty societies to develop comprehensive guidelines on the sedation of children outside of a monitored healthcare setting; That, until guidelines are established, our AMA discourage~~ oppose the administration of pre-procedural sedation to children outside of a monitored healthcare setting. (Report F, A-06) [See also: Resolutions 805, I-06] (Reaffirmed Report D, I-16)	Reconcile - This references a directive to action that was completed, but the policy has been amended to retain an internal position consistent with its original intent.
50.005R	Protection of Pre-school Children from Passive Smoking	That our AMA-RFS oppose the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or child-care purposes.	Reaffirm with editorial changes.

		(Substitute Resolution 17, A-94) [See also: AMA Policy H-60.954] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	
50.006R	Childcare at AMA Meetings	~~That our AMA survey recent attendees of the AMA section meetings as well as the HOD on whether or not they have brought their children to AMA meetings and on the desire and need for onsite childcare and report back on these results at I-16; and t~~That our AMA-RFS: (1) support the AMA offering organized childcare services at all AMA national meetings; and (2) Hospitality Committee and other relevant stakeholders~~organizations~~ publicize family friendly activity information within each meetings respective host cities. (Report F, I-15)	Reconcile - The initial request for a survey is outdated, but the rest of the policy should be retained with minor updates as this remains an ongoing topic of discussion within the AMA including at the current meeting in I-19 BOT Report 10.
80.003R	Reviewing the Effectiveness of Current Drug Policies	That our AMA-RFS (1) support the review of the effectiveness of current drug policies pertaining to illegal drug use; (2) support the review of the current availability of and access to evidence-based treatments for drug abuse and dependence; (3) support the review of ~~evaluate~~ the effectiveness of current medical training for primary care physicians in evaluating and treating drug abuse; and (4) monitor the work on this issue by both national and international organizations, including, but not limited to the National Institute of Drug Abuse, United Nations, WHO, UNODC, and UNAIDS. (Resolution 2, I-10)	Reaffirm with editorial changes.
90.001R	Emergency Preparedness	That our AMA-RFS: 1) ~~our AMA~~ commend the physicians and other volunteers who demonstrated the true spirit of medicine during the September 11, 2001 terrorist attacks, (2) ~~that our RFS~~ support the AMA's development and maintenance of a physicians volunteer database, and (3) ~~that our RFS~~ support the AMA's effort to educate physicians on natural and man-made disaster related topics. (Substitute Resolution 1, I-01)	Reaffirm with editorial changes.
100.001R	Code Status Requirements for Nursing Home Residents	~~Asked t~~That our AMA-RFS: (1) oppose any requirement that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care. ~~Also asked that the AMA urge other medical agencies and associations to (2)~~ oppose any legislative or regulatory attempts that	Reaffirm with editorial changes.

		would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care. (Substitute Resolution 8, I-97) (Reaffirmed Report C, I-07) [Also see AMA Policy H-140.945]	
100.002R	~~Physician-Assisted Suicide~~Education on Medical Aid in Dying	That our AMA-RFS support AMA's effort to provide national leadership through sponsorship of forums and dissemination of information regarding the ethical dilemma of medical aid in dying~~physician-assisted suicide~~ and other end of life decisions. (Substitute Resolution 28, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-12)	Reconcile - With the goal of retaining internal consistency of language within the RFS Digest of Actions and based on 100.005R, "Physician-Assisted Suicide" has been renamed "Medical Aid in Dying".
120.002R	Healthy Food Options for Shift Workers	That our AMA-RFS support encourage~~e~~ing companies who have shift workers to explore making healthier food options available to workers during the evening and nighttime hours. (Report H, A-09)	Reaffirm with editorial changes.
120.003R	Support of Calorie Labeling in Restaurants	That our AMA-RFS support working with state medical associations, state restaurant associations, state departments of health, and other interested parties to promote the display of~~create a method for displaying~~ nutritional information on restaurant menus and menu boards for all food and beverage items. (Resolution 4, I-08)	Reconcile - The AMA adopted H-150.945 Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants. Due to some states starting to display nutritional information, language has been slightly updated.
120.007R	Promoting Nutrition Education Among Healthcare Providers	That our AMA reaffirm H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage. (Resolution 4, I-18)	Rescind - This is simply asking to renew an existing AMA policy and does not need to be in the RFS Digest of Actions.
130.001R	Opting Out of Health Information Exchanges	That our AMA include in its current ongoing study of health information exchanges, concern for potential risks to patient privacy and safeguards against compromise of patient information. (Resolution 3, I-11)	Rescind - This asks for a report that was addressed by "Data Ownership and Access to Clinical Data in Health Information Exchanges H-478.988".
130.002R	Marriage Equality to Reduce Health Care Disparities	That our ~~AMA reaffirm H-65.973 Health Care Disparities in Same-Sex Partner Households; and that our~~ AMA-RFS support ending the exclusion of same-sex couples from civil marriage in order to reduce health care disparities affecting those gay and lesbian individuals and couples, their families and their children. (Resolution 5, A-10)	Reaffirm with editorial changes.
130.003R	Medical Confidentiality of Sexual Orientation	That our AMA-RFS ~~encourage our AMA to work to have the US Military change the interpretation of the "Don't Ask, Don't Tell" policy to exempt any~~oppose the use	Reconcile - "Don't ask, don't tell" is no longer active policy, but the principles behind this resolution are

	in the Military~~"Don't Ask, Don't Tell"~~	~~mention~~ of sexual orientation, same sex marriage or domestic partnerships obtained in patient-physician, or other patient-health care provider communications from being the basis for dismissal from the US Military in order to not impede the patient-physician relationship and to improve the provision of good medical care to all of our service personnel. (Resolution 1, I-09)	still relevant and are retained with an updated title.
130.004R	Access to Equivalent Benefits for~~dverse Effects of "Don't Ask, Don't Tell" on~~ Children and Other Dependents of Military Personnel with Same Sex Marriages	That our AMA-RFS~~ encourage our AMA to work to have our US military modify the "Don't Ask, Don't Tell" policy to provide~~ support US military personnel in legal same sex marriages having the ability to acknowledge these relationships and receiving~~to provide~~ equal death benefits and other benefits (including health care coverage) to the dependent children and spouses of legal same sex marriages as ~~now~~ provided to married US military personnel. (Resolution 2, I-09)	Reconcile - "Don't ask, don't tell" is no longer active policy, but the principles behind this resolution are still relevant and are retained with an updated title.
130.005R	Removing Barriers to Care for Transgender Patients	That our AMA-RFS: (1) support public and private health insurance coverage for treatment of gender identity and (2) oppose categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician. (Resolution 1, I-07)	Reaffirm with editorial changes.
130.006R	Cost-Effectiveness of Medicaid Eligibility Criteria for the Chronically Ill	That our AMA examine the appropriateness and cost-effectiveness of "the spend down option" to meet Medicaid eligibility criteria in the broader context of Medicaid reform with a report back at I-02. (Substitute Resolution 6, A-01) [HOD Resolution 102, I-01]	Rescind - Based on I-02 CMS Report 1, there was no evidence that the Medicaid "spend-down" was inappropriate and was not cost-excessive.
130.008R	Early and Periodic Screening, Diagnosis, and Treatment	That our AMA-RFS support guaranteed Medicaid coverage of basic preventative services and treatment of diseases found on screening for children and adolescents including those covered by the Early and Periodic Screening, Diagnosis, and Treatment component.	Reaffirm - No year listed in Digest, so we recommend reaffirmation so that the resolution has a reset sunset calendar.
140.001R	~~President Barack Obama's~~ Health Care Reform Plan	That our AMA-RFS (1) continue to advocate for health system reform which makes health insurance coverage accessible for all U.S. citizens; (2) support ~~the proposal to~~ require~~e~~ing all children to have health insurance as a strategic priority; (3) advocate for sufficient federal subsidy or tax credit amounts so that all U.S. citizens can afford to purchase health insurance; (4) support the ~~proposed~~ requirement for private insurers that children up to age	Reconcile - Updating for changes to the law and re-titling to retain relevance and broader applicability. Resolve (7) is a duplicate of Resolve (2) so it was deleted.

		26~~5~~ could continue family coverage through their parents' plan; (5) support working with the federal government to ensure that if federal programs are to be expanded, that proper checks and balances are in place to ensure that reimbursements reflect the actual cost of care and that patient access is not limited; and (6) support~~ensure~~ that under the National Health Insurance Exchange (or any similar proposed program) that participating insurers provide high quality, transparent services, and that their reimbursements reflect the actual cost of care~~; and (7) that our AMA support requiring all children to have health insurance as a strategic priority~~. (Report H, I-08)	
140.002R	Assessing the Health Care Proposals of the U.S. Presidential Candidates	That our AMA-RFS: (1) request that the AMA collect and disseminate details of the health care proposals of every declared candidate for U.S. President; and (2) that this resolution be forwarded to our AMA House of Delegates every four years prior to every Presidential election starting at I-19~~summarize the health care proposals of all candidates for U.S. President in a standardized format beginning at I-07~~. (Resolution 14, A-07)	Reconcile - This will be relevant to every Presidential election and is updated and retained.
140.003R	Health Care as a Right for All People~~Citizens of America~~	That our AMA-RFS assert that all people deserve access to quality, affordable, basic and preventative healthcare. (Substitute Resolution 11, A-07)	Reconcile - Amending the title to reflect the content of the resolution, which remains relevant.
140.004R	AMA-Health Care Delivery Task Force	That our AMA-RFS~~: (1)~~ support the create~~e~~ion of a multi-organizational task force of relevant stakeholders ~~involving groups including, but not limited to the AHA, DHHS, Families USA, Labor Unions, AARP, NFIP, etc. to research and meet in order to create a~~to develop consensus recommendations on a health care system or health care delivery principles that best serve the needs of the American public,~~ and (2) lead the discussion~~ using the goals and principles of the Health Access America as a starting point. (Substitute Resolution 28, A-97) (Reaffirmed Report C, I-07)	Reconcile to remove mention of specific organizations so that this remains relevant and broad. The principles of the "Health Access America" remain relevant as well.
150.001R	Promoting Prevention Strategies ~~in Waiting Rooms~~	That our AMA-RFS support the use of ~~encourage healthcare settings to place in their waiting rooms~~ interactive media promoting preventive health measures, empowering patients to become more proactive about their health. (Resolution 8, I-06) (Reaffirmed Report D, I-16)	Reconcile - The use of interactive media for patient education has broad applicability that can be applied beyond waiting rooms and retains the intention of the original resolution.

160.001R	Screening for Pre-Existing Conditions	That our AMA-RFS support health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, with community or modified community rating, in addition to guaranteed renewability. (Resolution 3, A-09)	Reaffirm with editorial changes.
160.004R	Use of Confidential Medical Information by Employers	That: (1) the RFS reaffirm its support for AMA Policy H-190.996, Employers' Violation of Patient Privacy with Group Medical Insurance Claim Forms and (2) the RFS Governing Council report back to the Assembly at I-99 on the AMA's advocacy efforts to safeguard patient confidentiality in employer self-insured plans. (Substitute Resolution 13, A-99) (Reaffirmed Report C, I-09)	Rescind. Policy is outmoded and directive is complete.
160.005R	Arbitration Agreements	That our AMA-RFS support ~~sponsor~~ legislation that would require third party payors to disclose any arbitration agreements to prospective clients prior to, or at the time of enrollment. (Substitute Resolution 26, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes.
170.003R	National Committee to Evaluate Medical School Closings	That our AMA-RFS support working with appropriate agencies to develop recommendations regarding the number of graduates of U.S. medical schools consistent with appropriate workforce needs. (Substitute Resolution 9, I-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes.
ZZ0.00ZR	Trainee Emergency Preparedness for the Inevitable Zombie Apocalypse	That our AMA-RFS: (1) support the CDC releasing and maintaining guidelines for zombie emergency preparedness, (2) support an educational mandate for zombie emergency preparedness training, (3) support residency and fellowship programs providing survival kits as part onboarding materials. (Resurrected Report Z, I-68)	Rescind - No longer relevant due to climate change replacing zombie apocalypse as the most pressing existential threat. Unclear why this carve-out was given special attention.
230.004R	Advocacy Regarding FICA Taxation for Housestaff	That our AMA-RFS support the AMA~~, through the RFS Governing Council, AMA Council on Medical Education, AMA Office of General Counsel and any other appropriate section or council,~~ studying the consequences of classifying housestaff as either employees or students for the purpose of FICA tax payment and take appropriate action (such as filing an amicus brief in Mayo) on this issue~~, and that our AMA report back at I-10 on any action taken on the issue of housestaff exemption from FICA tax payments~~. (Emergency Resolution 1, A-10)	Reconcile - While there's not enough information to strongly support or oppose housestaff designations as students or employees by tax status (no study directly addressed this), we can support a study and oppose taxation of federal student aid ("Taxation of Federal Student Aid H-305.962"). Furthermore, some of this issue is also addressed in "Securing Funding for Graduate Medical Education

			H-310.915”
230.005R	Eliminating Questions Regarding Marital Status, Childbearing and Dependent Children During the Residency and Fellowship Application Process	That our ~~AMA and~~ AMA-RFS: (1) oppose questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, and religion and (2) support the AMA working with the ACGME, NRMP, and other interested parties to eliminate questioning about marital and dependent status, ~~SorS~~ future plans for marriage or children, sexual orientation, and religion during the residency and fellowship application process. (Resolution 6, I-08)	Reaffirm with editorial changes.
230.006R	Defensive Medicine	~~Recommends t~~That our~~the~~ AMA-RFS: (1) affirm that defensive medicine exists in many forms that have variable and difficult to quantify economic consequences for patients, physicians, third-party payers, insurance providers and other parties involved in the delivery of health care; (2)~~That the AMA~~ affirm that defensive medicine in its many forms may result in adverse health effects on patients through exposure to unnecessary risk from tests and procedures as well as limited access to health care resources; and (3) supports~~that~~ the AMA continu~~e~~ing to work with other interested parties through legislative and public awareness activities to advocate for medical liability reform which would minimize the practice of defensive medicine. (Report F, A-08)	Reaffirm with editorial changes.
230.010R	DACA in GME	That our AMA reaffirm Visa Complications for IMGs in GME D-255.991 and Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986. (Resolution 5, I-18)	Rescind - This is a reaffirmation of HOD policy that is itself a reflection of 230.090R from the RFS.
240.001R	Telemedicine and Medical Licensure	That our AMA study how guidelines regulating medical licenses are affected by telemedicine and medical technological innovations that allow for physicians to practice outside their states of licensure. (Resolution 4, I-07)	Rescind - This is a complex issue that is no longer covered by this policy as the study has been done. **We would recommend that the RFS generate new policy more directly addressing the issue of interstate telemedicine.**
240.002R	Independent Regulation of Physician Licensing Exams	That our AMA-RFS support ~~advocate for~~ independent oversight of the creation, implementation and regulation of physician licensing exams, paying particular attention to conflicts of interest ~~created by bodies promulgating exams~~	Reconcile - The original request report was written, so the resolution is amended to retain the original intent of appropriate oversight.

		~~who then financially benefit from their administration. Asked that our AMA Board of Trustees study potential mechanisms of independent oversight regulation of the creation, implementation and regulation of physician licensing exams and that they report back at A-07. Asked that our AMA explore whether the NBME/FSMB/NBOMEs exclusive power to create licensure exams, validate them, and administer them, may represent a conflict of interest and/or a violation of anti-trust laws~~. (Resolution 1, I-06) (Reaffirmed Report D, I-16)	
240.006R	Feedback from Licensing and Board Examinations	That our AMA-RFS support ~~encourage~~ (1) the Federation of State Medical Boards and the National Board of Medical Examiners ~~to~~ provide<u>ing</u> examinees more detailed and specific performance feedback than currently provided, to allow examinees to identify areas of deficit and to facilitate educational improvement, and (2) all specialty boards ~~to~~ provide<u>ing</u> examinees more detailed and specific performance feedback than currently provided to allow examinees to identify areas of deficit and to facilitate educational improvement. (Substitute Resolution 2, I-00) (Reaffirmed Report C, I-10)	Reaffirm with editorial changes.
240.007R	Reporting Unqualified Residents	That the AMA-RFS support the recommendations in CME Report 8 (A-99), Alternatives to the Federation of State Medical Boards Recommendations on Licensure. (Report I, I-99) (Reaffirmed Report C, I-09)	Rescind - The report referenced is outdated with regards to more recent AMA-RFS positions.
240.008R	National Licensure for Physicians	That our AMA-RFS support the study of~~and report on~~ the feasibility and implications of national licensure for physicians. (Substitute Resolution 8, I-99) (Reaffirmed Report C, I-09)	Reaffirm with editorial changes.
240.009R	RFS Response to FSMB Recommendations on Licensure	That our AMA-RFS: (1) advocate that successful completion of one year of post-graduate training in an accredited residency program, as certified by the resident's program director, is sufficient to obtain an unrestricted medical license; (2) oppose state medical board oversight of medical students; ~~(3) support the efforts of the AMA Council on Medical Education to oppose the implementation of FSMB BD RPT 98-5 by state medical boards;~~ and (3<u>4</u>) in conjunction with the AMA, provide state and local medical societies with supporting materials,	Reconcile - Largely a reaffirmation, but reconciled to remove outdated policy and retain the remaining relevant positions.

		including model state legislation, that promotes AMA~~RFS~~ policy concerning training requirements for unrestricted medical licensure. (Substitute Resolution 6, A-99) (Reaffirmed Report C, I-09)	
240.014R	Psychotherapy for Medical Students and Residents	~~Recommended (1) t~~That the AMA-RFS: (1) support the distribution of~~seek updated information from each~~ state medical licensing board ~~on its~~ requirements for reporting mental health treatment or psychotherapy, and (2) oppose the use of knowledge of mental health treatment or psychotherapy to delay or prevent medical licensing~~that the RFS publish this information along with a reiteration of current AMA policy on reporting requirements for physicians who have received any form of psychiatric treatment in Code Blue and Resident Forum. This information can then be used by residents in conjunction with their state medical societies to effect regulatory change in the requirements for medical licensure~~. (Report C, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-16)	Reconcile - Simplified language to retain original intent of access to state medical board mental health treatment disclosures standards, expanded policy to be more consistent with current AMA-RFS positions opposing use of mental health treatment to prevent licensure, and removed references to outdated resources.
250.001R	CMS, Medicaid, and Health Insurance Corporation Ranking Systems	That our AMA-RFS support ~~current~~ AMA efforts to evaluate and distribute information about individual health insurers~~, as exemplified by BOT Report 11 (A-08)~~. (Resolution 10, A-08)	Reconcile - To remove reference to a prior AMA Report.
250.002R	Carve-outs and Discrimination in Managed Mental Health Care	That our AMA-RFS support ~~work to encourage~~ payors ~~to~~ eliminate~~e~~ing mental health and chemical dependency carve-outs so that benefits for mental health and chemical dependency are managed and administered like other health care services. (Resolution 5, I-00) (Reaffirmed Report C, I-10)	Reaffirm with editorial changes.
260.003R	NRMP All-In Policy	That our AMA-RFS does not support the current “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process. Also asked that the AMA work with the NRMP, and other external bodies (1) to revise match policy, including the secondary match or scramble process to create more standardized rules for all candidates and (2) to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants. (Report F, A-11)	Rescind - Based on Residency Match Systems and Timelines 260.019R we no longer broadly oppose an all-in Match and guard rails against a rapid change without careful thought and buy in are addressed in this newer RFS policy position.
250.004R	Protection of Residency Education	That our AMA-RFS oppose the role of external financial ~~support an educational campaign directed toward state and~~	Reconcile - Retaining original intent while removing reference to a

		~~federal legislators to inform them of the importance of encouraging managed care's participation in graduate medical education and to inform them of the potential adverse consequences of managed care's~~ influence on residency education. (Substitute Resolution 3, A-95) (Reaffirmed Report C, I-05)	1995 educational campaign effort to legislators.
260.006R	Competency-Based Learning Portfolios	That our AMA-RFS support the AMA ~~continue to~~ work<u>ing</u> with the ACGME and other appropriate bodies to define the usefulness of learning portfolios and their role in medical education. (Report E, I-10)	Reconcile with editorial changes.
260.007R	Support of Access and Flexibility to Breast Feeding During Required National Medical Exams	That our AMA-RFS support: (1) the provision of additional time during all standardized medical certification and licensing examinations to allow for pumping or nursing a baby per American Academy of Pediatrics recommendations<u>, (2)</u> ~~as well as to~~ <u>testing facilities</u> provid~~e~~<u>ing</u> a secured, private<u>,</u> and sanitary location separate from lavatory facilities<u>,</u> and <u>(3)</u> that testing locations with these facilities be designated and clearly identifiable at the time of exam registration. (Resolution 2, A-10)	Reconcile with editorial changes.
260.014R	Medical Student Training in Airway Management	That our AMA-RFS support ~~recommend~~ training in techniques and decision making in airway management of the unconscious patient for all medical students as part of their undergraduate medical education. (Substitute Resolution 1, I-97) (Reaffirmed Report C, I-07)	Reconcile with editorial changes.
260.016R	Providing Residency Applicants a Timely Response to Residency Application Outcome	That our AMA-RFS support: ~~amend HOD policy H-310.998 Residency Interview Schedules to read:~~ ~~H-310.998 Residency Interview Schedules~~ ~~The AMA encourages~~ <u>(1)</u> residency and fellowship programs ~~to~~ incorporat~~e~~<u>ing</u> ~~in~~ interview dates increased flexibility, whenever possible, to accommodate applicants' schedules<u>, (2)</u>~~. The AMA encourages~~ the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview<u>, and (3)</u>~~. The AMA encourages~~ residency and fellowship programs ~~to~~ inform<u>ing</u> applicants in a timely manner confirming receipt of their application materials and timely notification of when an applicant is no	Reconcile - Removing reference to HOD policy that this resolution was trying to amend to retain the RFS position statement.

		longer under consideration for an interview. (Resolution 1, I-13) [HOD Resolution 302, A-14]	
280.003R	Protecting Graduate Medical Education: Revisiting the All-Payer System	That our AMA-RFS support working together with other stakeholders to actively lobby the current Congress for legislation requiring all payers to contribute towards graduate medical education, while simultaneously continuing to lobby to protect Medicare and Medicaid Graduate Medical Education payments ~~and that our AMA report back on this issue at A-08~~. (Resolution 7, A-07)	Reaffirm with editorial changes.
280.004R	Securing Medicare GME Funding for Research and Outside Rotations	That our AMA-RFS: (1) support studying current funding mechanisms for residency training programs and potential funding limitations; (2) encourage research and extramural educational opportunities; and (3) oppose~~work to change current DME (Direct Medical Education)~~ regulations and funding guidelines which may limit research and extramural educational opportunities during residency training. (Resolution 12, A-07)	Reaffirm with editorial changes.
280.006R	Public Disclosure of Residency Revenue and Expenditures	That: (1) the RFS Governing Council study the feasibility of residency programs obtaining and disclosing revenues and expenditures related to residency training; (2) the RFS Governing Council report to the RFS Assembly at A-99 on current and proposed methodologies of Medicare GME funding; and (3) the RFS report to the Assembly on the feasibility of developing accounting techniques to report the annualized value of resident services. (Substitute Resolution 2, I-98) (Reaffirmed Report D, I-16)	Rescind - These are directives that were completed and the GME Finances Report occurred 20 years ago.
280.007R	Compensation for Teaching Physicians	That the AMA oppose the use of Medicare rules regarding reimbursement of teaching physicians for unsupervised services, by private payors and Medicaid unless the payor contributes to graduate medical education on a scale commensurate to Medicare's contribution to graduate medical education. (Report H, A-97)	Rescind - There is not a clear or actionable ask here and the relevant Medicare rules have changed since 1997.
280.009R	Second Residencies in Primary Care	That our AMA-RFS ask the AMA to seek reinstatement of full Medicare Direct Graduate Medical Education funding training institutions for residents who have completed the minimum years of training for first board eligibility and are seeking a residency in primary care or	Rescind - Addressed in 280.014R

		other shortage specialty, as defined by the Health Care Financing Administration (HCFA). (Substitute Resolution 20, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)	
280.017R	Funding of Education and Research Under Prospective Payment Plans	That our AMA-RFS endorse: (1) the concept that research, development and education are intrinsic components of the "product" medical care and as such, their costs should fairly be assumed by private and public medical insurance programs, health care plans and industry; and (2) ~~AMA Resolution 108 (A-84) which asked that the AMA endorse such a policy and ask those~~ asking relevant groups to strive toward a better balance between immediate medical cost containment and long-term concern for medical excellence and progress. (Substitute Resolution 19, A-84) (Reaffirmed Report C, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)	Reconcile - To remove reference to a past AMA resolution.
281.003R	Expansion of Economic Hardship Loan Deferment~~Eligibility Criterion for Economic Hardship Deferment 20/220 Pathway~~	That our AMA-RFS support~~include~~ language advocating for expansion of eligibility for economic hardship deferment for residents and fellows to the greatest degree possible in advocacy activities ~~(Directive to Take Action)~~. (Resolution 2, A-08)	Reconcile - Retitled to more appropriately reflect the resolution.
281.004R	~~Reinstatement of Economic Hardship Loan Deferment~~Alternate Mechanisms for Addressing Medical Debt	That our AMA-RFS ~~actively 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 post-graduate trainees with educational debt. (Late Resolution 1, I-07)	Reconcile - Rescinded reference to 20/220 pathway, which is obsolete and retained position on educational debt. Retitled to reflect these changes.
281.005R	Loan Repayment Program Resource	That our AMA-RFS research, compile, and maintain a comprehensive resource to include a hyperlink list of all the loan repayment programs across the country; and that access to this resource be a member-only feature of the AMA website. (Late Resolution 1, A-06) (Reaffirmed Report D, I-16)	Rescind - Directive to action that is not relevant as this information is more widely available. If a database is desired, a new resolution should be submitted.
281.006R	Federal Student Loan Program Interest Rates	That our AMA-RFS~~: (1)~~ support~~analyze models of~~ federal student loan ~~and student~~ loan consolidation programs that ~~interest rate regulations (including fixed and variable rates) and make recommendations to~~ maximize their effectiveness in addressing medical education debt and patient access to health care~~; (2) utilize data from the study of federal loan and student loan~~	Reconcile - To retain intent of supporting specific types of loan consolidation programs while removing reference to past/outdated policy.

		~~consolidation program interest rate regulations to enhance its lobbying efforts toward the reauthorization of the Higher Education Act; and (3) provide a report to the AMA-HOD and RFS-HOD at A-05 regarding the reauthorization of the Higher Education Act at A-05; and (4) that our AMA-RFS forward this resolution immediately to the AMA at I-04~~. (Substitute Resolution 4, I-04) (Reaffirmed Report D, I-14) [Became HOD Resolution 729: Adopted I-04]	
281.010R	Maintaining Financial Solvency During Residency Training	~~Recommended t~~That our AMA-RFS: (1) encourage resident physicians to work with hospitals and universities to examine the issue of student loan indebtedness and possible solutions including increased compensation packages; and (2) continue to work with the AMA to encourage resident physicians to inform legislators of the impact of financing graduate medical education on career choice, specialty choice, and practice location~~; and (3) report to the Assembly on the results of the survey of medical students being conducted by the AMA Division of Undergraduate Medical Education~~. (Report N, I-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)	Reconcile - To remove reference to remove reference to a past report.
281.011R	Student Loan Deferment	That~~: (1)~~ the AMA-RFS support: ~~work with the AMA-MSS and other interested parties to~~ develop ing a grassroots campaign to educate federal legislators on the expanding burden of medical education debt in an effort to promote the need for extending deferment of student loans for post-graduate training; (2) ~~that~~ the AMA lobbying the federal government for legislation that will achieve deferment of medical school loans for the entire residency and fellowship period. (Substitute Resolution 14, A-99; Reaffirmed, Report C, I-09)	Reaffirm with editorial changes.
281.012R	Student Debt ~~and Post 1986 Tax Changes~~	That our AMA-RFS continue to recognize the seriousness of the problem of the expanding burden of medical education debt and elevate to a top legislative priority~~; That our AMA collaborate with other medical and professional associations to seek sponsorship and support passage of legislation consistent with current AMA policy that would return to the pre-1986 tax status for interest on education related debt~~. (Resolution 8, A-98) (Reaffirmed Report D, I-16)	Reconcile - To remove reference to a 1986 tax status that is no longer relevant.

281.016R	Direct Loan Consolidation Program	That the AMA-RFS ~~and our AMA~~ support ~~the Individual Education Account/D~~direct l~~L~~oan c~~C~~onsolidation p~~P~~rograms. (Resolution 9, A-95) [See also: AMA Policy H-305.948] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Reconcile - To remove reference to a specific program and provide general support for loan consolidation programs.
281.019R	Student Loan Deferment During Residency	That our AMA-RFS ~~prepare a detailed report on AMA activities regarding medical student loan deferment during residency and make recommendations for further policy for consideration at the 1989 Interim Meeting. (RFS Substitute Resolution 24, A-89) In response to Substitute Resolution 24, the AMA-RFS adopted as amended Report D which reviewed the issue, AMA policy, and federal legislation, and asked that the~~: (1) ~~AMA~~ support efforts to grant forbearance to residents who request it without penalties, additional costs, or restrictions, but not to the exclusion of deferment; and (2) ~~AMA actively~~ oppose legislative efforts to curtail or eliminate the classification of residents as students for purposes of loan deferment~~; and (3) AMA-RFS continue to inform resident physicians of any federal legislation pending on student loans and encourage residents to write their Congressmen and Senators~~. (Report D, I-89) (Reaffirmed Report C, I-99) [See also: AMA Policies H-305.965 and H-305.961] (Reaffirmed Report D, I-16)	Rescind components of outdated policy referencing a directive to action from a A-89 resolution and inactionable items.
291.008R	Resident and Fellow Duty Hours and Quality of Training	That our AMA-RFS support ~~encourage~~ the Accreditation Council for Graduate Medical Education (ACGME) to not adopting the IOM report's call for protected sleep periods and for reducing the number of hours that residents can work without time for sleep to 16, until research shows improved patient care and safety; That our AMA encourage the ACGME to allow appropriate flexibility for different disciplines and different training levels within the current ACGME maximum duty hours standards; That our AMA work with other key stakeholders to continue to develop strategies for implementing optimal work schedules to improve resident education and patient safety in healthcare. (Emergency Resolution 2, A-10)	Reaffirm with editorial changes.
291.009R	Residents' and Fellows' Bill of Rights	That our AMA-RFS support: ~~adopt~~ a *Residents' and Fellows' Bill of Rights* that will serve as a testament to the organization's support for and commitment to the education and	Reconcile to include text of Resident/Fellow Bill of Rights so that it is preserved within our Digest of Actions ("Residents' and Fellows' Bill

		training of competent, conscientious residents and fellows by illuminating their rights and advocating for provisions that it believes all residents should be afforded, and that have not yet been designated as rights, and that 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. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.	of Rights H-310.912”).

		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. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living. (3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided. F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education. With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour	

		requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. ~~Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.~~ 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. ~~Also, that the *Residents' and Fellows' Bill of Rights* shall address 10 core themes spanning the aggregate of the graduate medical education experience (List of Rights attached as Addendum 1 to this document).~~ (Resolution 1, A-09)	
291.010R	Impact of Specialty Board Mandated	In order to accommodate leave protected by the federal Family and Medical Leave Act (FMLA), the AMA encourage all	Rescind - Covered by 291.012R.

	Residency Completion Dates on Parental Leave During Residency	specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year. (Resolution 2, A-09)	
291.011R	Provision of Child Care by Residency and Fellowship Training Programs	That our AMA-RFS: (1) begin collecting more comprehensive data on the provision of child care services or stipends for child care by residency and fellowship programs using the Freida database and (2) evaluate the progress made in the provision of child care and different models being utilized by training programs. (Resolution 4, A-08)	Reaffirm with editorial changes.
291.012R	Loss of Status Following Family Medical Leave Act (FMLA) Qualified Leave During Residency Training	That our AMA-RFS: (1) oppose requiring residents to repeat a year of training when returning to work following a leave that qualifies under the federal Family Medical Leave Act; and (2) support~~urge~~ the American Board of Medical Specialties and its member boards ~~to~~ being in compliance with the Family Medical Leave Act and ~~to~~ retracting any policies that do not comply. (Resolution 2, I-07)	Reaffirm with editorial changes.
291.013R	Monitoring of At-Home Call Implementation by Residency Programs	That our AMA-RFS: (1) oppose the use of at-home call if being used to circumvent the intent of current ACGME duty hour restrictions; (2) support working with the ACGME and other interested organizations to collect additional information on how residency programs nationwide are using at-home call rotations; (3) support working with the ACGME and other interested organizations to study the impact of at-home call on resident well-being, sleep patterns, and patient safety, commenting on issues such as, but not limited to, total hours worked, number of pages and phone calls received, and hours of continuous sleep; and (4) support working with the ACGME and other interested organizations to study and develop best practices for implementing at-home call in residency and fellowship programs. (Resolution 3, I-07)	Reaffirm with editorial changes.
291.014R	Resident and Fellow Leave Policy	That our AMA reaffirm existing AMA and AMA-RFS policies on resident and fellow leave. [AMA and AMA-RFS policies reaffirmed in lieu of Res. 5, I-06; See AMA Policies H-420.966, H-420.961, H-420.987, H-420.967, and AMA-RFS Policies 310.581R, 310.590R, 310.594R, 310.599R, 310.799R] (Report E, A-07)	Rescind - This only asks for reaffirmation of HOD policies.

291.016R	Resident/Fellow Work and Learning Environment	That our: ~~(1)~~ AMA-RFS ask the AMA to (1) ~~ask the Board of Directors of the Accreditation Council for Graduate Medical Education (ACGME) to reconsider the changes made in the Common Program Requirements for duty hours and the procedures for the approval exemptions at their meeting of February 11, 2003, and approve the original language and intent from June 2002 prior to the implementation of requirements on July 1, 2003; (2)~~ ~~AMA~~ study all options to address enforcement and compliance with the ACGME Duty Hour requirements ~~(JCAHO, legislation, private methods etc) with a report back to the House of Delegates at the A-04 meeting~~;(3) ~~AMA~~ study, develop, and promote a method of creating an environment for residents to safely report violations on resident duty hours without any repercussions; (4) ~~AMA~~ request an annual report to ACGME's Member Organizations from the ACGME, which includes the number of complaints received, the number not in compliance due to duty hours and working conditions and the action taken by ACGME, and that this report be indexed by specialty; (5) ~~AMA~~ continue to work with the ACGME to refine the duty hours standards, and work with ACGME and other appropriate entities to collect evidence on the impact of current standards in regards to patient and resident safety, resident education, and eliminating fatigue and sleep deprivation; (6) ~~AMA~~ support ~~the program module developed by the American Academy for Sleep Medicine to~~ educate~~ing~~ residency training programs on sleep deprivation and fatigue~~ that is scheduled to be ready for distribution by July 1, 2003; (7) AMA-RFS and the AMA-MSS continue working with groups such as the Committee of Interns (CIR) on collaborative efforts to see that duty hour reform is enforced and continue to work to improve working conditions for residents and fellows; (8) That our AMA conduct a 10-year survey to capture the attitudes and changes of residents on duty hours after the new ACGME guidelines to determine the effect on working conditions for residents and fellows;(9) That our AMA reaffirm policy H.310.928 and D. 310.999 by encouraging the Agency for Healthcare	Reconcile - The Common nProgram Requirements and duty hours have changed and the update to the policy reflects the changes and capabilities of the RFS.

		~~Research and Quality (AHRQ) to examine the link between resident work hours and patient safety in order to find solutions to the problems.~~ (Report F, A-03) [HOD Resolution 322, A-03] (Reaffirmed Report D, I-13)	
291.017R	Resident/Fellow Work and Learning Environment	That our AMA-RFS continue to: (1) work with other national resident/student organizations to make current hours reform work; (2) explore other options to address compliance with the ACGME Duty Hour requirements including, but not limited to confidential and anonymous reporting and study enforcement alternatives to the current ACGME standards; (3) support the AMA Council on Legislation as the coordinating body in the continued creation of legislative and regulatory options; and (4) work with the AMA Council on Medical Education to address compliance with the ACGME Duty Hour requirements. (Report F adopted in lieu of Resolutions 4 and 5, I-02) (Reaffirmed Report D, I-12)	Rescind - Covered in 291.016R.
291.018R	Fellowship Salaries	That our AMA-RFS: (1) ~~study the current system of~~ support multiple avenues for fellowship funding and salaries ~~with a report at I-02~~, and (2) encourage the ACGME and the ABMS to collect information on fellowship salaries from both accredited and nonaccredited programs to serve as a basis for the development of policy recommendations. (Report G, A-02) (Reaffirmed Report D, I-16)	Reconcile - The RFS and the AMA are aware of the multitude of ways to finance GME and the RFS supports all mechanisms to ensure that our physicians are well trained.
291.019R	Resident/Fellow Work and Learning Environment	That: (1) our AMA define resident duty hours as those scheduled hours associated with primary resident or fellowship responsibilities; (2) our AMA support a limit on resident duty hours of 84 hours per week averaged over a two-week period; (3) our AMA support on-call activities no more frequent than every third night and there be at least one consecutive 24 hour duty-free period day every seven days both averaged over a two-week period; (4) our AMA support a standard workday limit for resident physicians of 12 hours. Patient care assignments exceeding 14 hours are considered on-call activities; (5) our AMA support a limit on scheduled on-call assignments of 24 consecutive hours. On-call assignments exceeding 24 consecutive hours must end before 30	Rescind - Covered in 291.016R.

		hours. The final 6 hours of this shift are for education, patient follow-up, and transfer of care. New patients and/or continuity clinics must not be assigned to the resident during this 6-hour period; (6) our AMA support the inclusion of home call hours in the total number of weekly scheduled duty hours if the resident on call can routinely expect to get a less than 5 consecutive hours of sleep; (7) our AMA support a limit on assignments in high intensity settings of 12 scheduled hours with flexibility for sign off activities; (8) our AMA support that limits on duty hours must not adversely impact the organized educational activities of the residency program; (9) our AMA ask the ACGME to establish new requirements for mandatory and protected education time in residency programs that constitutes no less than 10% of scheduled duty hours; (10) our AMA support that scheduled time providing patient care services of limited or no educational value be minimized; (11) our AMA ask the Joint Commission on the Accreditation of Hospital Organizations (JCAHO) to create new resident work condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; (12) our AMA ask JCAHO to establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; and (13) our AMA-RFS support the AMA Council on Legislation as the coordinating body in the creation of legislative and regulatory options. (Report F, A-02) (Reaffirmed Report D, I-12) [See also: CME Report 9, A-02]	
291.020R	Resident/Fellow Work and Learning Environment	That our AMA: (1) may draft original, modify existing, or oppose legislation and pursue any regulatory or administrative strategies when dealing with resident work hours and conditions, (2) work with organizations such as the Accreditation Council for Graduate Medical Education (ACGME), the Joint Commission, and other appropriate organizations, toward finding solutions to the problem of work hours and conditions which would strengthen current work hours enforcement mechanisms, and (3) encourage the Agency for Healthcare Research and	Rescind - Covered in 291.016R.

		Quality (AHRQ) to examine the link between resident work hours and patient safety and to explore possible solutions to the problem of work hours and conditions. That our AMA-RFS Governing Council report back the RFS Assembly at A-02. (Report F, I-01) (Reaffirmed Report D, I-12) [See also: AMA Policy H-310.928]	
291.022R	Resident and Fellow Work Hours Reform 2001	That: (1) our RFS continue to make the improvement of hospital working conditions, including resident/fellow work hours, a top priority and report back at I-01 regarding the section's progress on this issue, (2) the RFS Governing Council work directly with other interested organizations using forums, workshops, and other methods to address the issue of hospital working conditions and resident/fellow hours, (3) our RFS ask the AMA to have the Council on Medical Education evaluate the scope of work hours violations by residency and fellowship programs and assess the ACGME's progress in curtailing these violations with a report at I-01, (4) our RFS ask the AMA to have the Council on Scientific Affairs work with other appropriate organizations to study the effect of resident/fellow sleep deprivation and fatigue on medical decision making, performance, and medical errors, (5) our RFS ask the AMA to have the Council on Legislation explore legislative strategies to enforce ACGME resident/fellow work hour standards and study the potential impact of state/federal legislation on work hours and teaching institutions with report back at I-01, (6) our RFS ask the AMA to have the Council on Medical Service study the feasibility of enforcement of resident/fellow work hour standards by state/federal regulatory agencies, and (7) our AMA Board of Trustees review recent activities by the AMA and other organizations related to resident and fellow working conditions reform and report back at 1-01. (Report F, A-01) (Reaffirmed Report D, I-16)	Rescind - Covered in 291.021R.
291.023R	Intern and Resident Work Standards	That our AMA-RFS support: (1) ~~support the~~ various ACGME-RRC standards as a template for reasonable resident work conditions; (2) ~~encourage~~ the development of effective sanctions for violation of ACGME resident work standards; and (3) ~~encourage the ACGME to~~ publishing the list of	Reconcile - Retaining original intent and removing reference to immediate forwarding.

		programs with work hour violations in print and in electronic form~~; (4) publish the list of programs with work hour violations in print and in electronic form; and (5) that this resolution be forwarded to the I-2000 meeting of the AMA HOD~~. (Substitute Resolution 1, I-00) (Reaffirmed Report C, I-10)	
291.026R	Supervision of Residents	That our AMA-RFS support ~~evaluate and advocate for the revision of the new HCFA rules concerning~~ Medicare reimbursement for teaching physicians to ensure: (1) more reasonable documentation requirements, (2) clarify and determine reasonable physical presence requirements, (3) expand the limited exception requirements for attending physician supervision to restore training for non-primary care residents at centers located in outpatient centers regardless of hospital affiliation. (Report F, A-97) (Reaffirmed Report D, I-16)	Reconcile to remove reference to HCFA rules as this is outdated. The remainder is still relevant.
291.027R	Extended Leave Policy for Residents	That our AMA-RFS support~~-ask the AMA to urge residency training programs, medical specialty boards and~~ the ACGME~~-to urge~~ and employers ~~to~~ provide~~e~~ing ~~for~~ extended leave of up to one year for resident physicians with extraordinary and long term personal or family medical tragedies without the loss of previously accepted residency training positions. (Substitute Resolution 11, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes.
291.028R	Misrepresentation of Degree of Supervision	That our AMA-RFS: (1) reaffirm support of appropriate supervision of residents and (2) support the AMA in its continued efforts to work with and monitor HCFA's implementation of the new Teaching Physician Guidelines. (Substitute Resolution 2, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)	Rescind - Covered by 291.026R.
291.030R	Resident Work Hours	Recommended that our AMA-RFS Governing Council continue to monitor resident working conditions, including working hours, and report back to the Assembly as appropriate. (Report G, I-95) [See also: AMA Policy H-310.957, H-310.979, H-310.981] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)	Rescind - Covered by numerous other policies.
291.036R	Strategies to Reduce Burnout in Medical Trainees	That AMA-RFS policy Intern and Resident Burnout 291.015R be reaffirmed. (Resolution 8, I-18)	Rescind - This is just a reaffirmation of RFS policy.
292.002R	Protection of Peer Review Evaluations During Litigation	That our AMA-RFS oppose the utilization of resident and fellow performance evaluations for any purpose other than providing educational feedback. And that	Reaffirm.

		our AMA-RFS specifically opposes utilization of any evaluations of resident and fellow performance during a litigation process. (Resolution 5, A-09)	
292.003R	Appropriate Use of 360-Degree Resident Evaluations	That our AMA-RFS support working with the Accreditation Council on Graduate Medical Education to: (1) study mechanisms used by residency programs to evaluate resident performance in the ACGME six general competencies, including 360-degree evaluation tools, ~~.~~ a~~A~~nd (2) ~~that our AMA work with the ACGME on~~ develop~~ing~~ standards for the use of 360-degree evaluations, including a determination of their validity in resident assessment, and methods to ensure that the content of individual evaluations remains confidential and legally protected. (Resolution 4, I-09)	Reaffirm with editorial changes.
292.005R	Increasing Resident and Fellow Awareness of Local Representation	That our AMA-RFS support~~ask~~ the ACGME ~~to~~ requiring~~e~~ institutions to annually disseminate to all residents and fellows the current full-text institutional due process rules for residents and fellows and the current names and contact information of residents serving on hospital committees and the responsibilities of their respective committees. (Substitute Resolution 5, A-00) (Reaffirmed Report C, I-10)	Reaffirm with editorial changes.
292.006R	Due Process for Housestaff in All Loss-of Employment Situations	That our AMA-RFS support proposed modifications to the ACGME Institutional Requirements that would expand the provision of a grievance process to situations including non-renewal of contract and other actions that would threaten the career of a resident physician. (Substitute Resolution 2, A-00) (Reaffirmed Report C, I-10)	Rescind - Covered by 292.001R.
292.009R	Due Process Grievance Procedures, and Graduate Medical Education Reform	That: (1) The AMA-RFS periodically distribute information on due process and contract agreements as outlined by the ACGME, AMA, and AMA-RFS to residents via AMA-RFS publications e.g. UMember MattersU, UCode BlueU, and UResident ForumU. (2) The AMA distribute AMA's publication, Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures to Chairmen of residency training program's graduate medical education committees and housestaff associations. (Report E, A-92) (Reaffirmed Items 1 and 2, Report C, I-02) (Reaffirmed Report D, I-12) [See also: AMA Policy H-310.950]	Rescind - This has to do with distributing materials that are outdated, but **we strongly recommend the RFS develop internal position statements with regards to sexual harassment**.

292.010R	Due Process System for Residency Programs	That the AMA-RFS maintain the following principles for ~~develop and report on a model~~ due process ~~system~~ for residency programs:~~. In response, the AMA-RFS adopted Report C, which enumerated fifteen recommendations for residency programs on due process.~~ (1) A personal record of evaluation should be maintained for each resident which is accessible to the resident. (2) A resident should have the opportunity to challenge the accuracy of the information in his/her resident record. (3) At least annually, but preferably semi-annually, the program director and teaching staff should evaluate each resident's performance and provide each resident with this evaluation. (4) Each resident should expect to continue to the next level of training, unless he/she is given adequate notice and informed of reasons he/she may not so advance. (5) Residents should be involved in the development of recommendations on policy issues, involving education and patient care including the mechanism for evaluation or resident performance. (6) There should be policies and procedures that define the bodies responsible for evaluation of residents and the function and membership of such bodies. These policies and procedures should provide for timely and progressive verbal and written notification to the physician that his/her performance is in question, and provide an opportunity for the resident to learn why it has been questioned. (7) There should be participation by residents in all institutional bodies involved in the evaluation of residents. Consideration should also be given to including staff physicians closely involved in housestaff interactions. Those residents participating should have full voting rights. Representatives of the housestaff should be selected by members of the housestaff. (8) These policies and procedures should also provide that when a resident has been notified of an adverse action, he/she has adequate notice and opportunity to appear before a decision making body to respond to the charges and introduce his/her own rebuttal. Dismissal from the program, the replacing of the resident on probation or otherwise depriving the resident of the property rights to which he/she is entitled in order to continue in	Reconcile to remove reference to a past report.

		the program constitutes an adverse action. 9) The fundamental aspects of a fair hearing are: a listing of specific changes, adequate notice of the right to a hearing, the opportunity to present and to rebut the evidence, and the opportunity to present a defense. (10) A hearing should be conducted and a decision reported to the resident in a timely manner thereby minimizing interruption of the resident's training. (11) The resident should be permitted to be accompanied by another physician or advisor at the hearing of his/her choice. (12) A record of the hearing should be made and retained for review by interested parties who have obtained the written consent of the resident. (13) The policies and procedures should include an appeal mechanism within the institution. (14) All matter upon which the decision is based must be introduced into evidence at the proceeding before the hearing committee in the presence of the resident. An appeal of the decision of the hearing is limited to matters introduced at the hearing and made available to the resident. (15) Pending a final decision of the adverse action by the appellate body for the program, the resident should be permitted to continue in the training program except in the extraordinary case where patient safety and well being would be in jeopardy in the hospital. (Report C, A-82) (Reaffirmed Report C, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-16)	
293.001R	Physician Scientist Benefit Equity	That our AMA-RFS support the concept that all resident and fellow physicians who function in a role as physician scientists are provided with benefits packages comparable to those provided to their peers in clinical residencies or fellowships ~~as detailed in AMA-RFS Policy 293.011R~~. (Resolution 1, A-07)	Reconcile - To remove reference to an RFS position.
293.004R	Housestaff Organizations	That our AMA-RFS (1) continue to support the development of independent housestaff associations as one option for resident and fellow physicians who wish to organize and advocate to improve or affect the quality of patient care~~; (2) be prepared to implement a national labor organization specifically for all eligible resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to~~	Reconcile - The legal restrictions were resolved almost 20 years ago for resident labor unions. CIR exists and is an option for residents. The RFS shall continue to support this option for residents.

		~~organize a bargaining unit under the National Labor Relations Act; and (3)~~(2) continue to vigorously support antitrust relief that would permit collective bargaining between groups of self-employed physicians and health plans/insurers/hospitals, and be prepared to implement a national labor organization for these physicians should antitrust relief occur. (Report F, A-99) (Reaffirmed Report C, I-09)	
293.006R	Collective Negotiations by Residents	That our AMA ask its representatives to the ACGME to continue their diligence in supporting inclusion of the following AMA proposed amended language into Section 1,B,3,e(1) of ACGME's Institutional Requirements: Section 1,B,3,e(1) Provision of an organization system for communication and resolution of resident concerns on all issues pertaining to resident educational programs, patient care and resident well being. Institutions must allow resident physicians the ability to form a resident organization and use it or other forums to facilitate regular assessment of resident concerns; (2) that the AMA approve a nationwide program offering supporting materials and telephone and on-site assistance to groups of residents seeking to form independent housestaff organizations advocating no actions resulting in withholding care; and (3) that the AMA study the potential affects on future resident demand for housestaff associations or unionizations should the NLRB rule that all residents are subject to legal protections under the NLRA and make recommendations as to ways in which the AMA can appropriately address those demands. (Report F, A-98)	Rescind - Original intent was accomplished as a directive to action and the remainder is not feasible. **We would recommend new policy if specific collective bargaining language is desired.**
293.007R	Collective Negotiations by Residents	That: (1) our AMA-RFS endorse the principles adopted by the AMA Board of Trustees regarding changes in the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements regarding collective negotiation for residents; (2) that the AMA seek to amend the ACGME Institutional Requirements to include the following: a) prohibit a teaching institution from impeding any efforts by the residents to create a residency organization b) require teaching institutions to engage in good faith	Rescind - the Amicus Brief was filed. Labor unions exist. Intent of resolution to be preserved in 293.004R.

		collective negotiations with resident organizations on issues of patient care and resident well-being c) forbid teaching institutions from retribution against individual residency for activity related to a resident organization; (3) that the AMA seek means to ensure enforcement of Institutional Requirements by ACGME; (4) that the AMA prepare an amicus brief for the National Labor Relations Board (NLRB) in support of the right of resident organizations to collectively negotiate with teaching institutions but opposed to actions that would withhold patient care; (5) that the AMA vigorously pursue legislation to amend the NLRB Act to create a special student-employee classification for residents that would grant resident organizations the ability to participate in binding collective negotiation without the ability to withhold medical care as a work action; (6) that the AMA provide sufficient resources through its Division of Representation to prepare resident organizational models and provide adequate staff support to resident as well as other physician groups seeking to form organizational entities. (Report F, I-97) (Reaffirmed Report D, I-16)	
293.008R	Exposure to Residency Contracts for First Year Residents Prior to Match Day	That our AMA-RFS support ~~ask~~ the Accreditation Council on Graduate Medical Education (ACGME) ~~to~~ requiring~~e~~ programs to provide representative first year contracts to medical students interviewing for positions within their program prior to the submission of rank list. (Substitute Resolution 15, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes.
293.009R	Rules for Resident Negotiations	That our AMA-RFS support the development of ~~study~~ appropriate guidelines for addressing and negotiating contract and employment disputes which affect trainees~~residents~~ as a group. (Resolution 18, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes.
294.005R	ACGME Allotted Time off for Health Care Advocacy and Policy Activities	That our AMA-RFS (1) advocate that ~~urge~~ the ACGME ~~to~~ acknowledge that "activities in organized medicine" facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; (2) ~~That our AMA~~ encourage all residency and fellowship programs to support their residents and fellows in	Reaffirm with editorial changes.

		their involvement in and pursuit of leadership in organized medicine; (3) ~~That our AMA~~ encourage the ACGME to adopt policy that every resident and fellow be allotted additional of time per year, beyond of scheduled vacation time, to be used for activities of organized medicine, including but not limited to, health care advocacy and health policy; (4) ~~That our AMA~~ support the study ~~the~~ of other barriers and possible options to overcome these barriers to resident and fellow involvement in of organized medicine, including but not limited to, health care advocacy and health policy. (Resolution 6, A-10)	
294.006R	Knowledge of Medical Costs Among Residents and Fellows in Training	That our AMA-RFS support the integration of cost-effectiveness education into medical training, including how to analyze and apply cost-effectiveness data to medical decision-making; ~~That our AMA work with the ACGME and other appropriate bodies to incorporate cost-effectiveness education into medical training, including how to analyze and apply cost-effectiveness data to medical decision-making in residency and fellowship training programs.~~	Reaffirm with editorial changes.
294.007R	Evaluation of Increasing Residency Review Committee (RRC) Requirements	That our AMA study residency/fellowship documentation requirements for program accreditation and their impact on program directors and residents with recommendations for improvement. (Substitute Resolution 9, A-07)	Reaffirm with editorial changes.
294.009R	Membership List Access	That the AMA-RFS Governing Council: (1) work with the AMA to facilitate expedited access by the state medical associations to the NRMP match list; and (2) explore additional mechanisms outside the NRMP match list to obtain new resident information for the AMA-RFS and individual state medical associations. (Substitute Late Resolution 7, I-04) (Reaffirmed Report D, I-14)	Rescind - Covered by 294.008R.
294.012R	Education and Regulation of Electrologists	That our AMA-RFS support ~~encourage~~ the appropriate agencies to establishing regulatory and practice guidelines for electrologic procedures including education in the prevention of disease transmission during hair removal procedures. (Substitute Resolution 1, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes.
295.002R	Protection Against delayed Residency Program Closure	That our AMA-RFS: (1) support~~encourage~~ medical specialty boards ~~to~~ adding delayed residency	Reconcile - Still very relevant in light of recent residency closures and

		program closure to its list of exceptions to the continuity of care guidelines, expanding the definition of hardship to allow residents to transfer to another residency program for completion of board eligibility requirements, (2) support~~encourage~~ each Residency Review Committee ~~to~~ perform~~ing a~~ timely emergency site visits to any residency program announcing delayed closure to ensure compliance with Accreditation Council for Graduate Medical Education (ACGME) established accreditation guidelines, and (3) support~~encourage~~ each Residency Review Committee ~~to~~ closely monitor~~ing~~ any residency program in delayed program closure to ensure continued compliance with the ACGME~~Accreditation Council for Graduate Medical Education~~ guidelines and ensur~~ing~~e appropriate sanctions are imposed, including possible immediate closure of~~r~~ the residency program, if these guidelines are transgressed~~, and (4) that the attached AMA Policy H-310.943 Closing of Residency Programs be Reaffirmed~~. (Amended Resolution 2, I-04) (Reaffirmed Report D, I-14) [See also: AMA Policy D-310.972]	removed reference of AMA policy for reaffirmation.
295.004R	Minimum Resident Benefits	That our AMA-RFS continue to monitor the revision of the "General Requirements" of the U Essentials of Accredited Residencies in Graduate Medical Education U for significant changes in benefits language, and act on them as appropriate within current AMA-RFS actions and AMA policies. (Report I, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09)	Reaffirm with editorial changes.
295.005R	Displaced Residents	That our AMA-RFS support ~~ask~~ the ACGME ~~to~~ streamlin~~ing~~e the process through which displaced residents can enter other residency programs. (Substitute Late Resolution 2, I-99) (Reaffirmed Report C, I-09)	Reaffirm with editorial changes.
295.006R	Enforcement of ACGME Requirements	That our AMA study and report back on methods the ACGME could use, in addition to probation and withdrawal of accreditation, to enforce its Institutional Requirements and RRC Program Requirements. (Substitute Resolution 11, A-99) (Reaffirmed Report C, I-09)	Rescind. Directed to AMA. AMA adopted thorough and comprehensive policy which governs the RFS: D-310.995 Enforcement of ACGME Requirements
296.001R	Evaluating Resident Transfers in and Out of Residency	That our AMA-RFS study the issue of resident transfers between programs to better identify the scope of this issue. (Resolution 2, A-14)	Rescind - Directive completed with RFS Report E A-17.

	Programs		
330.001R	Practice Expense	That our AMA actively oppose and advocate against HCFA's using the SMS as the sole source of data form which the specialty specific practice expenses per hour is calculated and that the AMA support HCFA's utilizing data from specialty society sources where that data exists. (Emergency Resolution 2, A-98) (Reaffirmed Report D, I-16)	Rescind. Outmoded, as it's now known as CMS.
330.002R	Payment for Federally Mandated Emergency Care	That our AMA-RFS support ~~actively advocate to HCFA and the Congress that~~ an equitable adjustment to the medical physician fee schedule ~~be developed~~ to provide fair compensation to offset the additional professional and practice expenses required to comply with EMTALA.	Reconcile - To remove reference to HCFA and retain original intent.
330.003R	Effective Communication with HCFA	That our AMA-RFS Governing Council meet with the Health Care Financing Administration (HCFA) to discuss the Medicare guidelines governing reimbursement for resident supervision during residency training with a report back the AMA-RFS Assembly. (Substitute Resolution 6, I-97) (Reaffirmed Report C, I-07)	Rescind - The RFS governing council cannot do this.
340.003R	Patient Prescriptions	That our AMA-RFS support ~~work with relevant organizations to~~ improving prescription labeling for visually or otherwise impaired patients and ~~to~~ increasing~~e~~ awareness of available resources. (Late Resolution 1, A-08)	Reaffirm with editorial changes.
340.004R	Improving Transfer of Care Communication	~~Improving Transfer of Care Communication: That our AMA-RFS investigate models of effective, efficient transfer of care communication, taking into consideration the use of electronic medical records.~~ That our AMA-RFS support effective and efficient transfers of care that include both digital documentation and verbal communication.	Reconcile - The policy language is out of date, but the intent is still relevant. The substitute position statement is intended to address the intent of the original position statement while making sure it is relevant for the future.
380.004R	Scope of Practice of Mid-Level Providers	That our AMA-RFS oppose the independent practice of mid-level providers in the interest of patient safety and provider competency. (Resolution 3, A-10)	Rescind - Covered by 380.002R.
380.005R	Radiation Oncology is not an Ancillary Service	That our AMA 1) affirm that radiation therapy is not ancillary to any service; 2) that any designation of radiation therapy as an ancillary service is inaccurate; and 3) oppose any legal or other designation of Radiation therapy as an "in-office ancillary service." (Resolution 5, I-08)	Rescind - Outdated policy issue.
380.007R	AMA Policy on Physician Provider	That our AMA investigate: (1) the publication of physician information on	Rescind - Completed directive to action.

	Information	internet websites; and (2) potential solutions to erroneous physician information contained on Internet websites. (Substitute Resolution 13, A-07)	
380.010R	Loan Payback in Shortage Areas	That our AMA-RFS support a ~~utilize U.S. Senate Bill 288, House of Representatives Bill 324, and other legislative resources to achieve~~ federal income tax exemption for state and federal loan repayment programs designed to improve physician supply in underserved areas. (Substitute Resolution 8, A-99) (Reaffirmed Report C, I-09)	Reconcile - The RFS cannot unilaterally advocate to congress and the specific bill numbers change every session
380.013R	Physician Diversity	That our AMA-RFS support ~~AMA policies 350.988, 350.991, 350.993, and 350.995 which encourage~~ increased representation by minorities in medicine. (Substitute Resolution 7, A-98) (Reaffirmed Report D, I-16)	Reconcile - The intent of the policy is to be retained while removing specific policy numbers that have changed and will continue to change.
380.014R	"No Compete" Clauses in Residency and Fellowship Contracts	That our ~~AMA and the~~ AMA-RFS strongly oppose contractual restrictions on the future practice of residents by institutions sponsoring residency training. (Substitute Resolution 5, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes
390.002R	Home Deliveries	That our AMA-RFS support ~~the recent American College of Obstetricians and Gynecologists (ACOG) statement~~ that ~~"~~the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers.~~"~~ (Resolution 6, A-08)	Reconcile - Updated to reflect a position statement without tying the position to a point in time recommendation by ACOG.
390.005R	Maternal/Fetal Conflict	That our AMA-RFS support the following statements: (1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle	Reaffirm.

		against compelled medical procedures should control in all cases which do not present such exceptional circumstances. (2) The physician's duty is to ensure that the pregnant woman makes an informed and thoughtful decision, not to dictate the woman's decision. (3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus. (4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate. (5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs. (Substitute Resolution 35, A-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10) [See also: AMA Policy H-420.969]	
400.001R	Criminalization of Providing Healthcare to Undocumented Residents	That our AMA-RFS: (1) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (2) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status ~~reaffirm AMA Policy H-440.876~~; (~~2~~3) work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of healthcare to undocumented residents; and (~~3~~4) oppose proof of citizenship as a condition of providing healthcare. (Resolution 6, A-07)(Modified and Reaffirmed I-19)	Reconcile - This policy reconciles multiple RFS and AMA policies to ensure that the patient-physician relationship is protected no matter what and that the healthcare setting is not also considered an arm of law enforcement by our patients.
400.002R	Opposition of Central Data Collections of Physicians (in Particular Residents) Named in Malpractice Suits:	That our AMA-RFS ~~implement AMA Policy H-355.983 which~~ oppose~~s~~ the reporting to the National Practitioner Data Bank of residents named in any malpractice suits which occurred during the required activities of residency training. (Substitute Resolution 13, A-97) (Reaffirmed Report C, I-07) (Modified and Reaffirmed I-19)	Reconcile
400.002R **[duplicate number]**	Primary Care Physician Liability Under Managed Care Contracts	That our AMA-RFS support strategies to minimize liability exposure of primary care physicians who are restricted in their treatment and referral decisions by the managed care plan in which they are	Reaffirm. Needs new policy number.

		participating. (Substitute Resolution 12, A-96) (Reaffirmed Report C, I-06)	
400.003R	Informing Residents about the National Practitioner Data Bank	That our AMA-RFS support the ~~continue to~~ dissemination~~e~~ of information regarding the National Practitioner Data Bank ~~through its communications vehicles~~. (Substitute Resolution 17, I-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)	Reaffirm with editorial changes.
410.001R	Addressing Decreased Access to Mammography	That our AMA-RFS support accessibility to screening mammography and oppose the inappropriate application use of the U.S. Preventative Services Task Force (USPSTF) mammography recommendations to limit access to reimbursement for screening with mammography when a patient and physician believe this to be a beneficial test for the patient. (Resolution 4, A-10)	Reaffirm.
410.003R	Payment for Vaccines by Medicare	That our AMA-RFS advocate that ~~lobby for~~ Medicare ~~to~~ pay for both the cost of the vaccine and the cost of administration by physicians of all vaccines covered under Medicare Part D. (Late Resolution 2, A-08)	Reaffirm with editorial changes.
410.005R	Covering the Uninsured as AMA's Top Priority	That~~: (1)~~ the AMA-RFS support ~~the following resolution: RESOLVED, That the number one priority of the AMA be~~ health system reform that achieves reasonable health insurance for all Americans which emphasizes prevention, quality and safety in such a way that addresses the broken medical liability system and the flaws in Medicare and Medicaid and improves the physician practice environment~~, (2) That the resolution be forwarded to the House of Delegates at the 2006 Annual Meeting, and (3)That the remainder of this report be filed~~. (Report I, I-05) [See also: AMA Policy H-165.847] (Reaffirmed Report E, A-16)	Reconcile - Retained key policy position and removed the context of an AMA resolution and immediate forwarding.
410.009R	Addressing Antibiotic Resistance	That our RFS support the recommendations in AMA Council on Scientific Affairs Report 3 (A-00), Combating Antibiotic resistance Via Physician Action and Education: AMA Activities. (Substitute Resolution 10, A-01) (Reaffirmed Report D, I-16)	Rescind - References supporting a 20-year-old report.
410.012R	Use of Bittering Agents as a Deterrent Against Ingestion of Potentially Toxic Household Products	That our AMA-RFS support any AMA efforts to encourage the use of bittering agents in household and other products which represent potential toxic hazards when ingested. (Substitute Resolution 19, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09)	Reaffirm.

410.013R	Low Literacy as a Barrier to Healthcare	~~That: (1) our AMA-RFS support the recommendations outlined in the Council on Scientific Affairs Report 1 (A-98); and (2) our AMA develop and implement initiatives to raise awareness among residents and fellows, of limited patient literacy.~~ That our AMA-RFS: (1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment; (2) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills; (3) encourages the allocation of federal and private funds for research on health literacy; (Substitute Resolution 4, A-99) (Reaffirmed Report C, I-09)	Reconcile - The original position referenced a report that has subsequently been amended (1-99), modified and reaffirmed (A-09), and amended again (A-13). Furthermore, it references a council that has changed its name and scope since the report. Therefore, we recommend adopting elements of the policy pertinent to the RFS to support the spirit of the original position to ensure continued AMA-RFS positions on this topic.
410.017R	Public Health Care Benefits	That our AMA-RFS support ~~actively lobby federal and state governments to restore and~~ maintenance of funding for public health care benefits for all ~~legal~~ immigrants. (Substitute Resolution 2, I-97) (Reaffirmed Report C, I-07) [See also: AMA Policy H-440.903]	Reconcile - Updating language for internal position and including all immigrants to be more consistent with current/recent RFS positions.
410.018R	Danger of Car Phones	That our AMA support further study into the dangers of the use of car phones and their impact on road traffic safety. (Substitute Resolution 20, A-97) (Reaffirmed Report C, I-07)	Rescind - Outdated policy. **Could write a new policy for mobile phones and touch screens in cars if needed in the future.**
410.019R	Latex Alternatives	That our AMA-RFS strongly encourage health care facilities to provide non-latex alternatives alongside their latex counterparts in all areas of patient care. (Substitute Resolution 3, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes.
410.021R	Latex Allergy Warning	That our AMA-RFS support labeling on medical products specifying “contains latex,” when applicable. (Substitute Resolution 6, A-96) (Reaffirmed Report C, I-06)	Reaffirm.
420.003R	The Study of the Federation	That our AMA-RFS support the goals of the Study of the Federation in order to strengthen patient advocacy, quality of care, and the profession of medicine. (Resolution 34, A-96) (Reaffirmed Report D, I-16)	Rescind - Outdated policy.
420.004R	Continued Support for the Agency for Health Care Policy and Research	That our AMA-RFS ask the AMA to call on Congress and the President of the United States to support the AHCPR at stable or increased levels of funding,	Rescind - Outdated directive to action.

	(AHCPR)	taking into account the additional financial burden imposed by the National Medical Expenditures Survey which is conducted at regular intervals. (Substitute Resolution 21, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)	
420.006R	Comprehensive Access to Safety Data from Clinical Trials	That our AMA-RFS support: (1) ~~urge~~ the FDA ~~to~~ investigating~~e~~ and developing means by which academic investigators can access original source safety data from industry-sponsored trials upon request; and (2) support the adoption of universal policy by medical journals requiring principal investigators to have independent access to all study data from industry-sponsored trials.	Reaffirm with editorial changes.
440.002R	Interoperability of Medical Devices	That our AMA-RFS ~~adopt the following statement on the Interoperability of Medical Devices: "The AMA~~ believes that (1) intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind;~~. The AMA also recognizes that, as in all technological advances,~~ (2) interoperability poses safety and medico legal challenges as well;~~. The~~ (3) the development of standards and production of interoperable equipment protocols should strike the proper balance to achieve maximum patient safety, efficiency, and outcome benefit.~~"~~ (Resolution 1, I-08)	Reconcile - The update to the policy reflects making the position internal and removes the quote to make the policy stand on its own.
460.002R	Tobacco Health Education and Advertising:	That our AMA-RFS ~~continue to use appropriate lobbying resources to~~ support programs of anti-tobacco health promotion and advertising. (Substitute Resolution 8, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09) [See also: AMA Policy H-490.959]	Reaffirm with editorial changes.
470.001R	~~Community Enforcement of~~ Restrictions on Adolescent Tobacco Sale~~Use~~	That our AMA-RFS~~: (1) inform its membership about 1-888-FDA-4KIDS, a toll-free phone number that allows the public to report sales of tobacco to minors and (2) continue to support enforcement of regulations on~~ oppose the sale of tobacco and nicotine products to minors. (Substitute Resolution 23, A-97) (Reaffirmed Report C, I-07)	Reconcile - The phone number is no longer accurate.

500.001R	AMA Physician Profile	~~(1)~~ That our AMA-RFS ask the AMA to ensure that the AMA Physician Profile and AMA Masterfile include the complete name of the training program ~~(i.e. "Program Name" as listed on the Accreditation Council for Graduate Medical Education (ACGME) website); (2) That our AMA ensure that the AMA Physician Profile and AMA Masterfile stop deleting from Physician Profiles and the Masterfile the name of the medical school or training program that is already listed and verified in the Physician Profile as it corresponds to the name of the institution at the time of the physician's graduation, and (3) That~~ and that if the AMA Physician Profile and AMA Masterfile need to be updated that it include the new updated name of a medical school or training program~~, this information be included~~ in addition to but not in place of the name of the medical school or training program at the time of the physician's graduation. (Late Resolution 3, A-08)	Reconcile - The policy was updated to reflect a simpler and more straightforward internal position statement that is flexible with changes in the future.
500.002R	AMA Physician Profile for Residents Transferring Programs	That our AMA-RFS support that the Physician Profile standard primary source verification confirming residency graduation states on the profile: "Completed Training: Program reports specialty training at this institution as Completed" for the program(s) from which a resident has graduated. (Late Resolution 4, A-08)	Reaffirm with editorial changes.
500.005R	Minimizing Unnecessary Mail	That our AMA-RFS support: (1) ~~offer to members~~ on applications and renewals for membership the ability to refuse any AMA periodicals they do not wish to receive as member benefits; (2) ~~offer to members~~ on applications and renewals for membership the ability to exclude their names from mailing lists that the AMA may provide to outside vendors or publishers; and (3) encourage~~e~~ing state, county, and medical specialty societies to establish similar mechanisms and policies. (Substitute Resolution 31, A-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)	Reaffirm with editorial changes.

500.007R	Discounted Registration Fees for AMA and Federation Seminars	That our AMA-RFS advocate that (1) the AMA adjust all of its registration fees to encourage and permit participation by resident physician and medical student members; and (2) ~~urge~~ all federation associations ~~to~~ discount their registration fees for seminars to accommodate their resident physician and medical student membership. (Resolution 10, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09) [See also: AMA Policy H-530.986]	**Reaffirm with editorial changes.**
510.001R	Resident Representation on the American Medical Political Action Committee Board of Trustees	That our AMA-RFS support the appointment of a resident member to the AMPAC Board of Directors. (Substitute Resolution 28, A-96) (Reaffirmed Report C, I-06)	Reaffirm.
520.001R	Residents in the AMA House of Delegates	That: (1) our AMA-RFS Governing Council include in the AMA-RFS Assembly handbook a semiannual report detailing information on AMA-RFS members sitting in the AMA House of Delegates including, but not limited to, name and state or specialty society representation; and (2) invite all resident members of the AMA House of Delegates to the AMA-RFS Assembly and caucuses. (Resolution 26, A-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)	Reaffirm.
530.002R	Definition of a Resident	That our AMA-RFS define a "resident" ~~change policy H-550.999, UDefinition of a ResidentU,~~ to include the following: (1) Members serving as their primary occupation in residencies approved by the ACGME or AOA; (2) Members serving as their primary occupation in fellowships approved as residencies by the ACGME or AOA; (3) Members serving fellowships in structured clinical training programs for periods of at least one year, to broaden competency in a specialized field, whether or not the program is affiliated with an approved residency training program; (4) Members serving, as their primary occupation, in a structured educational program to broaden competency in a specialized field, provided it is begun upon completion of medical school, residency, or fellowship training; (5) Members serving as active duty military and public health service residents who are	Reconcile to retain an internal position defining a resident consistent with the AMA Bylaws.

		required to provide service after their internship as general medical officers or flight surgeons before their return to complete a residency program~~; Also asked that the AMA change its bylaws (Section 7.10) to reflect this amended definition~~. (Report K, A-97) (Reaffirmed Report D, I-16)	
550.002R	Expanding Underrepresented Minority Voices in the AMA-RFS	That the AMA-RFS~~: 1) create bylaws to specifically and systematically outline how a minority physician organization may gain representation in the RFS national assembly; 2)~~ promote increased involvement in the AMA and AMA-RFS by underrepresented minorities by continuously researching the major underrepresented minority physician organizations with a focus on the level of involvement of resident and fellow members in each organization, on the percentage of AMA members in each organization, and on the level to which each minority physician organization desires to be involved with the AMA-RFS~~; 3) leadership work with the Specialty and Service Society (SSS) to determine the needed steps that minority physician organizations would have to take to become seated members of the AMA-HOD.~~	Reconcile - The reconciled position reflects the values of the RFS and our efforts to promote a diverse workforce within the scope of what the RFS can accomplish.
550.004R	AMA-RFS Leadership Handbook	That: (1) our AMA-RFS staff and Governing Council design a Leadership Handbook outlining the structure and function of the RFS, leadership positions, and state society contacts; (2) that our AMA-RFS encourage state, county, and specialty societies to develop similar materials; and (3) that our AMA-RFS make the Leadership Handbook available at the Annual and Interim Meetings and upon request. (Substitute Resolution 3, I-97) (Reaffirmed Report C, I-07)	Rescind/combine with 550.002R
550.005R	Centralized Resource for Listing Residency and Fellowship Vacancies	That our AMA-RFS work to create and maintain a centralized resource that lists available residency and fellowship vacancies for its membership. (Substitute Resolution 25, A-97) (Reaffirmed Report C, I-07)	Reaffirm.

550.007R	Fiscal Affairs of the Resident and Fellow Section	That the Governing Council to provide an annual fiscal report for the previous year at the Annual Meeting. (Substitute Resolution 18, A-78) (Reaffirmed Report C, I-88) (Reaffirmed Report C, I-98) (Reaffirmed Report D, I-16)	Rescind - 1978 policy asking for a fiscal report at every annual meeting that we do not do and is not relevant to the Section since the GC doesn't directly manage the RFS finances.
550.008R	2013-2016 Working Plan	Asked that: In the realm of National Meetings: (1) The RFS Governing Council should work with the AMA to encourage RFS participation between meetings and that: a) the RFS should continue to work to ensure that the MSS/RFS research poster symposia continues to be held at a national meeting, b) the RFS Governing Council will continue to work with staff to increase resident and fellow attendance at leadership training events, including the National Advocacy Conference and AMA leadership retreats; (2) The RFS Governing Council should continue to improve the process of election procedures to ensure adequacy, transparency and integrity of the results; (3) The RFS Governing Council should continue to work to improve content at national meetings that will be relevant to members and that will engage them in the core areas of AMA involvement, Advocacy, Public Health, Community Service, Legislative Policy, Leadership Development and Membership. In the realm of Advocacy: (4) The RFS should continue to make preserving and improving GME funding and addressing future physician workforce issues a key priority of our advocacy actions; (5) The RFS Governing Council should continue to annually identify key issues and mobilize the grassroots network to involve our section in advocating for RFS friendly positions on said issues and continue to educate the general assembly on these issues; (6) That the RFS should continue to work with other resident and fellow based organizations to ensure that the RFS serve as the national spokesperson for all resident and fellow centered issues including student debt, graduate medical education, medical licensure, and resident work hours.	Rescind.

		In the realm of Membership and Outreach: (7) The RFS and RFS Governing Council should investigate mechanisms to increase retention of members as they transition from one section to another, including: a) members transitioning from the MSS to RFS, b) members transitioning from the RFS to the YPS, and c) members transitioning out of IPM programs; (8) The RFS should continue to work with the MSS And the YPS to improve mentoring strategies and increase mentoring opportunities such as combined networking events, mentoring panels, combined working groups and specific events targeted by specialty, year, or location; (9) The RFS should continue to examine and improve the role of the regions within the RFS, which should include: a) current contact information for region leadership and their contact information available online for access by members; b) the current level of activity in each region and ways to increase involvement; c) the roles and responsibilities of the region leadership; d) novel ways to improve communication, foster leadership and increase membership; e) collaboration with MSS and YPS Sections, including joint region meetings and community service events; (10) The RFS Governing Council should work to establish local membership liaisons that will work directly with GME programs to reach out to residency programs and recruit members; (11) The RFS Should continue to work with AMA membership staff to assist with planning local membership recruitment programs and coordinate the involvement of local RFS leaders in said programs; and (12) RFS leaders should continue to encourage Section participants to introduce the Introduction to the Practice of Medicine program to their relevant academic and medical center faculty. In the realm of Communication: (13) The RFS and RVS Governing Council should work to establish online social media portals to encourage involvement in RFS activities and increase RFS awareness; (14) The RFS Governing Council should investigate methods to ensure there is effective communication with the region	

		leadership on a regular basis; (15) the RFS Governing Council should establish a mechanism to provide Governing Council updates and direct communication to our membership and work with AMA staff to ensure that these updates be disseminated to all RFS members; and (16) The RFS Governing Council should actively work to increase utilization of the RFS listserv and make it available to new members. In general, the Committee recommends that: (17) the RFS recommend that a Working Plan be developed by the Committee on Long Range Planning for the RFS Governing Council and approved by the assembly at least every 3 years. (Late Report H, I-13)	
560.003R	Resident Representation on Residency Review Committees	That our AMA consider appointing resident physicians to residency review committees currently without resident members by using its ex-officio positions on the committees. (Substitute Resolution 1, A-87) (Reaffirmed Report D, I-97) [See also: AMA Policy H-310.996] (Reaffirmed Report D, I-16)	Rescind - Outdated policy as residents are now included on these committees.
560.004R	Resident Representation on the Internal Medicine Residency Review Committee	That our AMA request all Residency Review Committees utilize peer-selected resident representatives to serve as voting members at all meetings of the committee for at least a one year term preceded by a six month term as an observer. (Substitute Resolution 2, A-98) (Reaffirmed Report D, I-16)	Rescind - Outdated policy as residents are now included on these committees.
560.005R	Peer-Nominated Representation on Institutional Councils and Committees	That our AMA-RFS: (1) encourage the ACGME to require that resident representatives on institutional GME Committees be peer-selected and (2) ~~study ways to ensure~~ advocate that the resident representatives on institutional GME Committees play a meaningful role at their institutions. (Substitute Resolution 9, I-99) (Reaffirmed Report C, I-09)	Reaffirm with editorial changes
570.002R	Communication between the AMA-RFS Governing Council and State Society Resident and Fellow Sections	That our AMA-RFS (1) establish a list of state and specialty society resident physicians section chairpersons; and (2) publish a list of state and specialty society resident physicians section chairpersons in the Annual and Interim Assembly meeting handbooks and proceedings. That our AMA-RFS Governing Council attempt to contact each state and specialty society resident physicians section chairperson prior to	Rescind - Combined with 550.004R.

		each AMA-RFS Assembly meeting. (Substitute Resolution 7, I-91) (Reaffirmed Report C, I-01) (Reaffirmed Report D, I-16)	
580.002R	Strategic Plan	AMA-RFS The following strategic plan for AMA- RFS was adopted for 2010-2011: In the realm of Membership: 1. The RFS should work with the MSS, membership staff, YPS, and County and State medical societies, to develop longitudinal membership drive initiatives that encompass all aspects of physician training from medical school graduation to completion of residency and fellowship training; 2. The AMA-RFS should ensure that there is an RFS-GC member and staff member who is in regular contact with the AMA membership staff and who will serve in an advisory role to the membership department in regards to the creation and implementation of RFS membership initiatives; 3. The AMA-RFS should work with the AMA membership staff to research and develop new membership incentives tailored to prospective RFS members In the realm of Advocacy: 4. The RFS will work with staff and local medical societies to secure additional funding and resources to increase resident activism at the National Advocacy Conference and Lobby Day; 5. The RFS continue to schedule RFS national lobby day concurrently with State and Specialty societies, while at the same time maintaining a direct interaction with the MSS during MSS lobby day; In the realm of Communication: 6. The AMA-RFS should publicize the RFS Facebook page, and utilize the Facebook page to create discussion and interaction among members; 7. The GC should appoint a member to serve as a moderator over the AMA-RFS website, Facebook page, and e-mail publications, who will be responsible to post information to the sites as well as moderate and/or create discussion topics;	Rescind - No longer relevant.

		8. The RFS Voice should be continued as a print mailing to RFS members, and the RFS should augment print mailings with an on-line newsletter over national and regional list-servs; 9. The RFS should work with the AMA to gather new and current members' e-mail addresses and maintain a members' e-mail database; In the realm of the RFS Regions: 1. The RFS should conduct a thorough examination of the role of the regions within the RFS including the function of the Regional Council, improved communication within the regions, and expansion of regional leadership; 1. The RFS should set the goal of planning with region leadership one to two local-regional events in centers of high concentration of physicians in training; In General the Committee recommends that: 1. The RFS GC report back to the RFS from time to time regarding the progress of each of these recommendations, with a first mandated report back at A-11; 1. The RFS mandate that a strategic plan should be developed for the section at least every 3 years. (Report F, A-10)	
580.004R	Demographics	That our AMA-RFS: ~~(1) determine~~ supports mechanisms to strengthen ties with Specialty Societies and improve logistical support for members involved through their Specialty Societies ~~(i.e. Region 8); (2) determine a system to apportion Specialty Society delegate and alternate delegate positions in the RFS assembly that accounts for the number of RFS members represented by Specialty Societies and ensures broad Specialty Society participation; (3) examine the ability of the Region structure to meet the stated goals of disseminating RFS information to local members, increasing RFS membership, and increasing involvement of RFS members at the regional and local level; and (4) that the RFS Governing Council report back to the RFS Assembly regarding the progress of the above~~	Reconcile - The update reflects changes to the section that have been accomplished since 2009 and continue to support specialty society representation

		~~recommendations by A-09.~~ (Report G, A-08)	
580.008R	Communication of Meeting Materials Deadlines	That at each meeting of the AMA-RFS, the Governing Council provide detailed information about the dates of and hotel information for the next meeting in both printed form and on the AMA-RFS home page. (Resolution 7, I-00) (Reaffirmed Report C, I-10)	Rescind - Directive completed and included in IOP update.
580.009R	AMA-RFS External Resolutions	That our AMA-RFS include in the AMA-RFS delegate package and in the AMA-RFS Handbook information explaining the options for each resolution and the process for determining how resolutions are forwarded to either the AMA-RFS assembly and/or the AMA-HOD. (Substitute Resolution 5, I-97) (Reaffirmed Report C, I-07)	Reaffirm.
580.010R	Background Information on Resident and Fellow Section Resolutions:	That our AMA-RFS~~: (1)~~ require the authors of resolutions to provide pertinent references and relevant existing AMA policy on the issue~~ and (2) provide each delegate a copy of the reference committee materials at the beginning of each Assembly Meeting~~. (Substitute Resolution 9, A-97) (Reaffirmed Report C, I-07)	Reconcile - To remove outdated components.
580.015R	RFS Reference Committee Reports	That: (1) AMA-RFS members not on the reference committee not be admitted to its executive session unless invited; and (2) members of a reference committee write and/or review its report prior to the presentation of its findings to the AMA-RFS Assembly. (Resolution 7, A-80) (Reaffirmed Report C, I-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)	Reaffirm.
580.016R	GME Delegates	Recommended (1) that a system for establishing the number of, the selection process for, and the caucusing and seating arrangements of GME Delegates be outlined by the AMA-RFS Governing Council through collaboration with the CLRP as part of a “pilot project”; and (2) that a report be presented to the Assembly at I-12 but no later than A-13. (Report F, A-12)	Rescind - Report completed and resolution is outmoded.

580.017R	2013-2016 Working Plan	AMA-RFS In the Realm of National Meetings: 1. The RFS Governing Council should work with the AMA to encourage RFS participation in a second business meeting to occur after the annual between meetings and that: a. The RFS should continue to work to ensure that the MSS/RFS research poster symposia continues to be held at a national meeting; b. The RFS Governing Council will continue to work with staff to increase resident and fellow attendance at leadership training events, including the National Advocacy Conference and AMA leadership retreats; 2. The RFS Governing Council should continue to improve the process of election procedures to ensure adequacy, transparency and integrity of the results; 3. The RFS Governing Council should continue to work to improve content at national meetings that will be relevant to members and that will engage them in the core areas of AMA involvement, Advocacy, Public Health, Community Service, Legislative Policy, Leadership Development and Membership; In the realm of Advocacy: 1. The RFS should continue to make preserving and improving GME funding and addressing future physician workforce issues a key priority of our advocacy actions; 1. The RFS Governing Council should continue to annually identify key issues and mobilize the grassroots network to involve our section in advocating for RFS friendly positions on said issues and continue to educate the general assembly on these issues; 1. That the RFS should continue to work with other resident and fellow based organizations to ensure that the RFS serve as the national spokesperson for all resident and fellow centered issues including student debt, graduate medical education, medical licensure, and resident work hours. In the realm of Membership and Outreach: 1. The RFS and RFS Governing Council should investigate mechanisms	Rescind - No longer relevant and much is covered in other working plans below.

		to increase retention of members as they transition from one section to another including: a. Members transitioning from MSS to RFS; b. Members transitioning from the RFS to the YPS; c. Members transitioning out of IPM programs; 1. The RFS should continue to work with the MSS and the YPS to improve mentoring strategies and increase mentoring opportunities such as combined networking events, mentoring panels, combined working groups and specific events targeted by specialty, year or location; 1. The RFS should continue to examine and improve the role of the regions within the RFS, which should include: a. Current contact information for region leadership and their contact information available online for access by members; b. The current level of activity in each region and ways to increase involvement; c. The roles and responsibilities of the region leadership; d. Novel ways to improve communication, foster leadership and increase membership; e. Collaboration with MSS and YPS Sections, including joint region meetings and community service events; 1. The RFS Governing Council should work to establish local membership liaisons that will work directly with GME programs to reach out to residency programs and recruit members; 1. The RFS should continue to work with AMA membership staff to assist with planning local membership recruitment programs and coordinate the involvement of local RFS leaders in said programs; 1. RFS leaders should continue to encourage Section participants to introduce the Introduction of the Practice of Medicine program to their relevant academic and medical center faculty; In the realm of Communication: 1. The RFS and RFS Governing Council should work to establish online	

		social media portals to encourage involvement in RFS activities and increase RFS awareness; 1. The RFS Governing Council should investigate methods to ensure there is effective communication with the region leadership on a regular basis; 1. The RFS Governing Council should establish a mechanism to provide Governing Council updates and direct communication to our membership and work with AMA staff to ensure that these updates be disseminated to all RFS members; 1. The RFS Governing Council should actively work to increase utilization of the RFS list-serve and make it available to new members; In general, the Committee recommends that: 1. The RFS recommend that a Working Plan be developed by the Committee on Long Range Planning for the RFS Governing Council and approved by the assembly at least every 3 years. (Late Report H, A-13)	
580.020R	Naming Conventions for AMA-RFS Policy/ Internal Operating Procedures Revision	That our AMA-RFS will form an ad-hoc committee broadly representing the membership of the Assembly for the purpose of reviewing and revising the AMA-RFS IOPs with a progress report at I-18. (Resolutions 1,17, A-18)	Rescind - Directive completed and included in IOP update.
590.001R	Update on the 50 State Membership Initiative	Update on the 50 State Membership Initiative: That our AMA-RFS will: 1. ~~Membership Committee work with AMA-RFS Staff to c~~Continuously update state and specialty society RFS information ~~as outlined in the Late Report 1~~ (A-09). 2. ~~Membership Committee work with AMA-RFS Staff to obtain the necessary information in order to utilize the flow chart model (see Supplement 1) for state RFS leadership contact information and also utilize this model in order to appoint RFS leadership where necessary and possible~~. Work to try and ensure a diverse representation of states, specialties, gender identity, sex, ethnicity, sexual orientation, and age within appointed position.	Reconcile - The timeframe for the previous reports has passed, so statement 4 has been sunset, but most of the position still holds merit. The policy is updated to reflect that the RFS Governing Council may assign the responsibilities to themselves, staff, or committees other than the Membership Committee. Furthermore, language was updated to reflect the diversity of the section.

		3. ~~Membership Committee provide updated informational reports of the Fifty State Resident and Fellow Membership Initiative at I-10 and A-11.~~ ~~4. Governing Council and the Membership Committee work with each state and specialty society RFS to increase membership and e~~E~~ncourage~~ increased participation and activity of its membership both at the state and national level. ~~5~~4. ~~Governing Council and the Membership Committee e~~E~~ncourage~~ and assist with the formation of ~~RFS~~Resident and Fellow Sections (RFS) in those states that do not have a formally organized RFS but have an active and interested group of physicians in training ~~as recommended in Late Report 1~~ (A-09). (Report I, A-10)	
590.002R	Enhancement of Membership Retention During Educational Transitions	That our AMA develop systems to allow state medical associations access to medical student match data and membership information for the purpose of membership retention and outreach without breaching existing contractual obligations; That our AMA study means to improve communication between state medical associations and our AMA for purposes of membership, recruitment, and retention, particularly during times of transition between medical school, residency, and fellowship. (Resolution 7, A-10)	Rescind - Outdated and former directive to action
590.003R	Enhancing Involvement of New Meeting Attendees	That our RFS-CLRP develop specific criteria for the use of At-Large positions; That the RFS pilot the use of At-Large positions and a program to incorporate new attendees and non-voting members into existing positions, within the purview of our AMA-RFS IOPs as well as state and specialty society procedures, prior to the commencement of the meeting at I-10; That the RFS-CLRP report the results of the pilot at A-11 and the Assembly vote to determine if the pilot becomes permanent. (Report H, A-10)	Rescind - Outdated request and some of this is already done now.
590.004R	Developing a Mentoring Program for New AMA-RFS Attendees	That our AMA-RFS work to create a mentoring program to welcome new attendees to the section's meetings including, but not limited to, linking mentors and mentees of the same region to sit near each other during RFS business, apprising the mentee of	Reaffirm.

		evening social activities, and contacting the mentee before the subsequent meeting. (Report L, I-09)	
590.005R	Expanding AMA Participation by Minority Scholar Award Winners	Expanding AMA Participation by Minority ~~Scholar Award Winners~~Physicians: That our AMA-RFS support increase~~ing~~ recruitment and retention of minority physicians including but not limited to current and future Minority Scholar A~~a~~ward winners ~~(including minority scholar award winners)~~ by developing ~~a~~ strategic plans for leadership development ~~and that our AMA-RFS report back on this issue at A-09.~~ (Resolution 8, A-08)	Reconcile - We attempted to update the policy to reflect the spirit of the policy while expanding the scope to cover values commonly evoked by the RFS.
590.009R	Facilitating a Smoother Transition ~~From~~Through the Medical Student Section (MSS), ~~to the~~ Resident and Fellow Section (RFS), and Young Physician Section (YPS)	That our AMA-RFS work with the MSS and the Young Physician Section (YPS) to implement methods to facilitate the transition between the sections. (Substitute Resolution 8, A-97) (Reaffirmed Report C, I-07)	Reaffirm with editorial changes including the title.

APPENDIX II
RFS DIGEST POSITIONS RESCINDED BY A-19 RFS REPORT B: INTERNAL OPERATING PROCEDURES RENEWAL

Policy No.	Title	Text	Recommendation
540.003R	Balloting Procedures	That our AMA-RFS study alternate procedures for balloting including, but not limited to: (1) coordinating with the MSS,OMSS, and any other AMA entities to use pre-existing AMA balloting equipment before HOD sessions; (2) developing or having outside vendors develop a unique computer program to handle AMA-RFS elections; (3) using an existing Internet or non-Internet based ballot counting computer program; and implement such measures found to be most appropriate by Interim 2015. (Resolution 15, A-15)	Covered by RFS IOP Section V.G.
550.001R	Leadership positions within the AMA-RFS	RFS Internal Operating Procedures (IOPs) modified to clearly define and clarify the process for electing leaders of	Covered by RFS IOP Section V.

		our AMA-RFS, including candidate eligibility (see amended IOPs). (Report G, A-09)	
550.009R	RFS Caucus Vote Mechanism	That following the conclusion of each House of Delegates meeting, not to exceed 30 days, our RFS Delegate and Alternate Delegate will provide a brief summary of ad hoc policy actions of the RFS Caucus as to allow related resolutions to be written with existing deadlines. (Resolution 6, A-17)	Covered by RFS IOP Section XIII.E.
560.001R	Standing Committees	That our AMA-RFS Governing Council shall annually appoint standing committees including, but not limited to, long range planning, public health, medical education, legislative awareness, membership and the poster symposium, composed of members of the Section to serve annual terms to further the mission of the Section; The Governing Council shall make an open solicitation of applications from the members of the section and shall select from among those who have applied; Should there be insufficient applications in order to adequately staff these committees, the Governing Council shall be empowered to make direct solicitations and appointments to the committees. (Report E, A-08)	Covered by RFS IOP Section XI.
560.002R	AMA-RFS Committee Reports	That our AMA-RFS representatives on all AMA committees be required to give either a formal written or verbal report twice a year, at the Interim and Annual meetings of the AMA-RFS, beginning with the A-03 meeting of the AMA-RFS. (Late Resolution 1, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report D, I-13)	Covered by RFS IOP Section XI.
560.006R	AMA-RFS Leadership Nominations and Appointments	That all persons nominated or appointed by the AMA-RFS for positions on AMA councils and committees or as representatives of the AMA-RFS to be resident physician members of the AMA. (Report I, I-98) (Reaffirmed Report D, I-16)	Covered by RFS IOP Section V.C, Section X.
560.007R	RFS Policy on Ad Hoc Committees and Task Forces	The AMA-RFS adopted Report J which set guidelines for the formation and conduct of AMA-RFS ad hoc committees and task forces. (Report J, I-85) (Reaffirmed Report C, I-95) (Reaffirmed, Report C, I-05) (Reaffirmed Report E, A-16)	Covered by RFS IOP Section XI.E.9.

570.001R	IOP Changes to Modify Governing Council Officer Position	Modifications to the AMA-RFS Internal Operating Procedures (IOP) were adopted to change the AMA-RFS Governing Council Membership and Outreach Officer Position to a Member-at-Large Position. This broadens the scope of the position. (Report F, A-09)	Covered by RFS IOP Section IV.A.
570.003R	Neutrality of Governing Council During Elections	That our AMA-RFS Governing Council members maintain a neutral status in elections by: (1) Not wearing campaign materials, except their own. (2) Not acting as campaign manager for any candidate. (3) Not endorsing candidates from the podium. (4) Not endorsing candidates as a council. (5) Not endorsing candidates through the use of one's Governing Council title. (6) Using discretion with respect to their personal endorsements. (Substitute Resolution 24, I-91) (Reaffirmed Report C, I-01) (Reaffirmed Report D, I-16)	Covered by RFS IOP Section V.D.1.h.
580.001R	Sectional Delegate Election Process	IOP changes were made to the Sectional Delegate Election Process in order to facilitate the HOD process and ensure maximum participation by elected section delegates and sectional alternate delegates (see updated IOP). (Report E, A-10)	Covered by RFS IOP Section V.I.3.
580.003R	Resolution and Report Submission Deadlines	The following IOP Changes were adopted: Resolutions or Reports that are submitted after the 42-day deadline but 7 days prior to the Assembly meeting are considered Late Resolutions; Resolutions submitted within 7 days of the meeting or after the meeting has been called to order are considered Emergency Resolutions. (Report E, A-09)	Covered by RFS IOP Section IX.I.3.
580.005R	Voting Mechanisms	That the voting system used in the RFS Sectional Delegate and Alternate Delegate elections be: an approval-based, plurality-at-large voting system in which the voter may select up to and including the number of candidate positions and a majority of votes is required. (Report H, A-08)	Covered by RFS IOP Section V.I.3.c.
580.005R [**duplicate number**]	Election Procedures for RFS Sectional Delegates and Alternate Delegates	That: (1) the RFS Governing Council study various voting mechanisms that consider geographic as well as specialty representation and report back at I-07; and (2) the RFS study how a regional structure could be utilized for conducting Sectional Delegate and Alternate Delegate elections in a fair and equitable manner and report back at I-07 with changes to the Internal Operating	Covered by RFS IOP Section V.I.3.c.

		Procedures (IOP) as is appropriate. (Report F, A-07)	
580.006R	Election Procedures for RFS Sectional Delegates and Alternate Delegates	That: (1) the RFS Governing Council study various voting mechanisms that consider geographic as well as specialty representation and report back at I-07; and (2) the RFS study how a regional structure could be utilized for conducting Sectional Delegate and Alternate Delegate elections in a fair and equitable manner and report back at I-07 with changes to the Internal Operating Procedures (IOP) as is appropriate. (Report F, A-07)	Covered by RFS IOP Section IX.H.3.
580.007R	Specialty and Military Representation Count toward Quorum in the RFS Assembly	That: (1) the AMA-RFS change its quorum requirements to Twenty percent (20%) of the authorized representatives representing at least fifteen states and five national medical specialty organizations, military or federal agencies for the Business Meeting of the RFS and (2) that this resolution become effective as of the I-06 business meeting of the AMA-RFS. (Resolution 2, A-05) (Reaffirmed Report E, A-16)	Outdated.
580.014R	Absentee Ballots for AMA-RFS Positions	That our AMA-RFS Assembly accept no absentee ballots. (Resolution 8, A-85) (Reaffirmed Report C, I-95) (Reaffirmed Report C, I-05)	Covered by RFS IOP Section V.D.2.
580.018R	Interpretation of Governing Council Responsibilities Regarding Actions of the RFS Sectional Delegate Caucus	That our AMA-RFS Governing Council Report on ad hoc actions of the AMA-RFS Caucus identify the names and endorsing groups of all attending members of the Caucus. (Resolution 9, I-16)	Covered by RFS IOPSection XIII.E.4.
580.019R	AMA-RFS Sunset Mechanism Procedure	(1) That our AMA-RFS Governing Council present actionable sunset recommendations to RFS policy via a yearly report at our Annual Meeting; (2) That each adopted resolve or recommendation clause within an RFS policy shall be considered individually with regard to the sunsetting process; (3) That our AMA-RFS annually review ten-year-old RFS policies and recommend whether to (a) reaffirm the policy, (b) rescind the policy, (c) reconcile the policy with more recent	Covered by RFS IOP Section IX.J.

		and like policy, or (d) make editorial changes which maintain the original intent of the policy; (4) That each RFS sunset recommendation regarding RFS policy may be extracted from the Consent Calendar and handled individually by our Assembly, but may only be adopted or not adopted; (5) That an action of the RFS Assembly that retains or updates an existing RFS policy shall reset the sunset "clock," making the reaffirmed RFS policy viable for ten additional years; (6) That defeated RFS sunset recommendations be reaffirmed for one year, to be readdressed via RFS Governing Council report or resolution from the RFS Assembly at or prior to the next RFS Annual Meeting; and (7) That nothing in this policy shall prohibit a report or resolution to sunset an RFS policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current RFS policy, or has been accomplished. (Report E, I-17)	
590.011R	Transition from Medical Student Section (MSS) to Resident and Fellow Section	Recommended that medical students (1) who have been accepted into residency training programs but wish to stay in MSS be awarded "Official Observer" status in the AMA-RFS; and (2) medical students accepted into a residency program beginning within six months and not registering in the MSS be allowed to credential as AMA-RFS delegates. (Report F, I-86) (Reaffirmed Report C, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)	Does not exist within AMA Bylaws.

To: Zarah Iqbal, MD, MPH

From: Pratistha Koirala, MD PhD

Date: October 23, 2019

Subject: AMPAC Report

AMPAC is the AMA's Bipartisan Political Action Committee. AMPAC's mission is to identify and support candidates for Congressional offices, whether it is a new candidate for office who will make physicians and patients a top priority, or a candidate running for reelection who is a proven friend of medicine.

AMPAC Board Members and staff have been working tirelessly to amplify the voice of physicians and medicine on Capitol Hill. This upcoming year promises to be exciting as we enter the 2020 United States election cycle; 34 out of 100 seats in the Senate and all 435 seats in the House of Representatives will be contested and the lead up to November 3, 2020 will include primary races across the country. AMPAC will be working to elevate medicine-friendly candidates in their campaigns across the country.

Accomplishments

- Election day is less than one year away and AMPAC will be actively investing in candidates that have shown either a track record of support for AMA policy stances or are new medicine-friendly politicians running for Congressional office.

- National Advocacy Conference will be held in Washington, DC on February 10th to the 12th. Registration is currently open on the AMA website.

- Hands-on educational training sessions for physicians interested in running political campaigns or running for office themselves are held annually. These annual events are open to all interested AMA members, so be on the lookout for registration for 2020 events. 2019 events include:
    - The AMPAC Candidate Workshop, held on March 1-3, 2019, focuses on giving physicians the skills needed to serve as a successful political candidate, including speech writing, debate practice, and organizing a campaign. The next workshop will be held in March 2020.

    - The AMPAC Campaign School will be held on September 26-29, 2019. This intensive workshop trains physicians to organize and run a successful campaign. It includes sessions on polling, drafting a message based on constituent interests, public speaking, development of radio ads, and more. This event uses a state-of-the-art flipped classroom approach to learning that maximized participant learning and skill building.

- Get a taste of AMPAC Campaign School at the AMA Interim Meeting in San Diego and attend an 'Insiders "How to" Guide to Running and Winning a Campaign' which will be held Sunday November 17th, 2019 in Grand Hall C.

Key Insights

- For any AMA-RFS member interested in learning more about AMPAC, or with an interest in taking part in the AMPAC Candidate Workshop or Campaign School, please reach out to the AMA-RFS AMPAC Board Member (Pratistha Koirala, MD PhD; pratisthakoirala@gmail.com) or visit http://www.ampaconline.org/

To: Zarah Iqbal, MD, MPH

From: Kimberly Chernoby, MD, JD, MA

Date: October 15, 2019

Subject: Council on Ethical and Judicial Affairs Update

CEJA has been hard at work, meeting twice between A-19 and I-19.

CEJA looks forward to submitting three reports for consideration by the HOD at I-19. They are as follows:

- "Competence" This report examines physicians' ethical obligations in light of our obligation as a profession to provide competent care to patients.
- "Global Health" This report examines obligations of physicians and trainees when embarking on medical service trips.
- "Discrimination by Patients" This report examines the ethical obligations of physicians and health care systems when patients manifest bigotry and discrimination when seeking medical care.

CEJA will also be hosting an open forum at I-10 scheduled for 9:30-11:00 on Monday, November 18. The topic of this forum will be identifying gaps in the *Code of Medical Ethics*, specifically on interprofessional relationships and physicians interactions with government agencies. More information is available in the Speakers Letter.

Finally, CEJA continues to have a busy judicial function having held approximately twenty hearings between A-19 and I-19.

To: Zarah Iqbal, MD, MPH

From: Benjamin Meyer, MD

Date: October 22, 2019

Subject: CLRPD Council Update

The AMA Council on Long Range Planning and Development (CLRPD) studies and evaluates the long-range objectives and policy development process in order to make recommendations to the AMA Board of Trustees on the strategic issues related to AMA's vision, goals and priorities.

Your Council on Long Range Planning and Development met on June 7, 2019 in conjunction with the AMA Annual Meeting. Topics that were discussed included:

- New members were welcomed to the Council
- Cybersecurity
- Governance practice of state medical associations
- Tasks set forth by the AMA Board of Trustees for the Council
- A Board of Trustees update from Drs. McDade and Kobler

Your Council on Long Range Planning and Development will be meeting on November 15, 2019 in conjunction with the AMA Interim Meeting.

AMA AMERICAN MEDICAL ASSOCIATION

To: Zarah Iqbal, MD, MPH

From: Luke V. Selby, MD

Date: October 25, 2019

Subject: CME Update

CME, as always, has been broadly focused on issues across the continuum of medical education. Our constant areas of discussion / outreach include medical student assessment and the scoring to step 1, the match (and decreasing the number of unmatched residents), resident wellness, and maintenance of certification. At I-19 we have reports on healthcare finance in undergraduate medical education (CME 2-I-19), standardizing the licensure timeline across states (CME 3-I-19), changes in board certification impacting addiction medicine specialists (CME 4-I-19), and funding of GME spots through the VA (CME 6-I-19). We will obviously be paying attention to all items relating to medical education brought forth to the HOD, and will likely collaborate closely with the RFS.

AMA AMERICAN MEDICAL ASSOCIATION

To: Zarah Iqbal, MD, MPH

From: Meenakshi Davuluri, MD, MPH

Date: October 23, 2019

Subject: Council on Medical Service – Council Report for I-19

Dear fellow RFS Members,

The council has been active as always since our last meeting in June. We are excited to present our reports at this meeting in Sunny San Diego. The council has been working on reports to address specific resolutions brought to the council from previous meetings as well as council initiated reports for issues pertinent to the American Medical Association. This memo briefly highlights our activities. As always, should you have any questions – please do no hesitate to reach out to me.

- Medical Homes and Telemedicine – Resolution 215 from I-18 was referred to the council for evaluation. We have discussed various possibilities and are final recommendations can be found in CMS report that will be presented at Interim. We will be discussing the role of state licensing boards, the scope of practice of licensing boards, and the role of telemedicine within these domains.

- The council is also working on reports regarding financial incentive programs as well as challenges with risk stratification and adjustment within alternative payment models. The council's reports are focusing on the physicians' perspective and methods allowing for a multi-disciplinary approach to best address these issues.

- Lastly we are addressing the continued concern surrounding drug pricing. A report that we will be presenting at this meeting will address methods to better improve reference pricing for drugs. We are looking to expand these reference prices to the international market to better provide cost comparisons. We are also looking to address additional ways to provide cost-containment strategies for pharmaceuticals.

As always, we are continuously in touch with our staff in DC to ensure that we are up to date on all policy changes that may impact our AMA as well as our reports. Our council has had excellent board liaisons to ensure continued open communication amongst the board and CMS. We look forward to sharing our reports at I-19.

To: Zarah Iqbal, MD, MPH

From: Hans Arora, MD, PhD

Date: October 23, 2019

Subject: Council on Legislation Update to RFS, 2019 Interim Meeting

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The AMA Council on Legislation met on Friday, September 20, 2019 in Washington, DC. Council members who were available the day(s) prior to the meeting had an opportunity to meet with their federal legislators to discuss three issues: surprise billing, regulatory relief (MACRA/MIPS), and firearm-related legislation. Reports from the AMA Alliance, AMPAC, and BOT were presented to the Council.

Current Legislative Issues

- Surprise billing
  - Protect patients from out-of-network billing and preserve patient access to hospital-based care by holding insurers accountable for addressing their own contributions to the problem.
  - Establish benchmark rates that are fair to all stakeholders in the private market; benchmark rates should include actual local charges as determined through an independent claims database.
  - Establish a fair and independent dispute resolution (IDR) process to resolve disputes about payments from insurers to unaffiliated providers for services rendered out of network to their enrollees.
  - Require insurers to maintain adequate provider networks to give patients timely access to physicians, including hospital-based emergency physicians & on-call specialists.
- Regulatory relief
  - Implement annual positive payment updates. MACRA in its current form included modest payment updates to the Medicare Physician Fee Schedule, but left a six-year gap from 2020-2025 where no updates were scheduled.
  - Extend the advanced APM incentive payments
  - Implement technical improvements in order to reduce the burden associated with MIPS participation
  - Continuous improvement should be a central focus of MACRA implementation, which should be reflected in continued evolution of the MIPS and APM programs.
- Preventing Gun Violence
  - Senate support/advancement for H.R. 8 (passed by the House of Representatives), the Bipartisan Background Checks Act of 2019.
  - Support for NIH and CDC funding specifically for epidemiological research on gun violence as part of any final Fiscal Year 2020 appropriations legislation.

Washington Report Summary

Maternal Health, surprise billing, drug pricing, gun violence, vaping and e-cigarettes are all under consideration by federal legislators. With a very limited number of days left in the calendar year, the only *required* item that needs to be passed is the annual appropriations bill. Unfortunately, with regards to many priority issues, Senate Majority Leader Mitch McConnell has been openly avoiding controversial votes for items which he does not believe President Trump will sign in order to ensure that at re-election time that Republicans will benefit from the “Trump halo” effect. In a divided government, we often see that real legislative changes are only made in odd number years (the even years are focused on elections). Congress is aware that healthcare, particularly the COST of healthcare, is the number one issue for voters. This is why both drug pricing and surprise billing are such high priority issues. We are hoping to

see an open dialogue on surprise billing, but obviously insurers are less interested in real reforms. The current approach being proposed in Congress for insurers to pay out-of-network physicians at the median in-network rate clearly benefits the insurers. The favorable Congressional Budget Office (CBO) score of the recently introduced bill, interestingly, derives 80% of savings from lowering IN-network costs. A number of members of Congress, particularly physician members, are working towards an independent-dispute resolution (IDR) process bill that would be similar to what is being done in New York state, though progress has been slow thus far. Former Secretary of HHS-turned Florida Congresswoman Donna Shalala has been a big proponent of surprise billing reform and IDR and has been working with other members of Congress to generate much-needed support. The complicating factor that has been plaguing the discussion is the very large role that private equity groups that own large staff companies have been playing in driving up the costs of healthcare. On the regulatory side, there continues to be discussion about the (unexpected) massive proposed overhaul of the Evaluation & Management coding requirements in the Physician Fee Schedule (PFS). The Common Procedural Terminology (CPT) committee has also been hard at work.

Select bills discussed with high level summaries:

- H.R. 3 Drug Price Negotiation Summary – establish an international price composite and give HHS the authority to negotiate the prices on 250 select drugs each year.
- S. 400 / H.R. 1098 Blocking Deadly Fentanyl Imports Act – Would withhold foreign aid from countries from which there is a known high origin of illicit fentanyl (e.g. China).
- H.R. 4004 Social Determinants Accelerator Act of 2019 – provides local communities funding and tools to implement solutions to social determinants of health.

Advocacy Resource Center (ARC)

The Council received state-by-state updates on the CVS-Aetna merger, Medicaid expansion, medical liability reform, reversing the nation's opioid epidemic, private payer reform, public health, scope of practice, and telemedicine. Further details can be found on the ARC website at: https://www.ama-assn.org/advocacy/physician-advocacy/state-advocacy. As always, the Council recommends that members refer to the ARC's website to see what the AMA is doing in your state, and encourages you to bring these issues to your colleagues to show them how the AMA is advocating on behalf of them and their patients at the local level.

Draft Model Legislation

One of the explicit roles of the Council is to develop, review, and recommend model legislation for approval by the AMA Board of Trustees. This legislation can then be used by state and federal legislators in a manner consistent with AMA policy. Model legislation can be found here: https://www.ama-assn.org/advocacy/physician-advocacy/ama-model-bills
Model bills discussed by the Council included:

- Minor Consent to Vaccines – AMA Policy H-440.830
- Health & Safety of Tattooing Act – AMA Policy H-440-909 Regulation of Tattoo Artists & Facilities

Additional topics

Additional topics discussed by the Council include a standing discussion on the status of augmented intelligence (AI) in healthcare, as well as updates on substance use disorder regulations (42 CFR Part 2). Immigration policies, the AMA's 2019 Compendium of Graduate Medical Education Initiatives Report (which will be sent from COL to Council on Medical Education for additional review) which details the breadth of GME financing initiatives occurring across the country in order to support GME-related advocacy, digital medicine/telehealth, and clinical laboratory testing payment and regulation.
The AMA is currently exploring a Privacy Framework with regards to patients' data privacy and ownership, and the Council has since initiated a Data Privacy Working group to develop future board reports on the issue.

To: Zarah Iqbal, MD, MPH

From: Laura Halpin MD PhD, RFS CSAPH Councilor

Date: October 21, 2019

Subject: CSAPH Council Update

Since the Annual Meeting, the Council on Science and Public Health has met once virtually to discuss reports for the Interim Meeting AMA-HOD as well as other projects. We discussed the following during our meeting on September 11, 2019:

Upcoming Reports:

The council will be bringing the following reports to I-19:

-Mandatory Reporting
-Real-World Data and Real-World Evidence in Medical Product Decision Making
-Patient Medical Marijuana Use in Hospitals

The Council is in the process of developing work plans for following reports for A-19:

-Transformation of Rural Community Public Health Systems
-Edible Cannabis Products and Benefits/Harms of Cannabis Legalization/Cannabis Update
-Physician Involvement in State Regulation of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to TBI
-Chemical Variability in Pharmaceutical Products
-Compassionate Release for Incarcerate Patient (BOT Report)

Educational Sessions:
We are working with the Organization of State Medical Association Presidents on the Forum for Medical Affairs educational session. The topic of this year's session is "The Health Impact of Climate Change Preparing Your Communities and Practices". It will focus on the health effects of climate change and how we as physicians can prepare and advocate for change. This session will be health on Sunday November 17,2019 from 1-3:30 in the Manchester Grand Hyatt at the Interim meeting.

Please reach out to me at anytime with if you have questions or if there is anything I can help with:
laura.e.halpin@gmail.com

To: Zarah Iqbal, MD, MPH

From: Toms Vengaloor Thomas, MD

Date: October 17, 2019

Subject: IMG Section Governing Council Update

It is a pleasure to provide a report on the following IMG Section activities.

Strategic Plan
The Governing Council developed its 2019-2020 IMG Section Strategic Plan.

IMG Recognition Week
The IMG Section celebrated IMG Recognition Week October 21-27 with the theme: "IMGs Moving Medicine." The following initiatives were made available:

- One-minute video with 5 IMG Section members illustrating how they are making a difference
- Newsletter and IMG Section web site promotion
- Employee spotlight promotion on AMA digital screen about IMGs
- Interview between Drs. Kevin King and Tani Malhotra which will appear on Social Media
- AMA News story on "**How IMGs have changed the face of American medicine"**

This will be an annual event to establish more awareness about IMGs and the IMG Section. IMG non-members will also be invited to join the AMA.

I-19 Meeting

I. The IMG Section has submitted three resolutions for the AMA-Interim Meeting of the House of Delegates which we hope the Resident and Fellows Section will support.

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

II. Joint Reception: Partnering with the Women Physicians Section to have a joint reception on Saturday, November 16 at 7:30 pm in Harbor A.

III. Educational Programs: The AMA-IMG Section is offering the following educational programs during the Interim Meeting:

A. Saturday, November 16 – IMGS 22ND Congress Assembly Meeting

- Todd Askew, AMA Senior Vice President, Advocacy – "Addressing the Challenge of Equitable Drug Pricing in the Era of Precision Medicine"

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.

B. Sunday, November 17 – IMGS Busharat Ahmad, MD Leadership Development Program

- Guest speaker: Colonel Arthur Athens, "Back to the Basics: The Fundamentals of Leadership". Colonel Athens retired from the Marine Corps in July 2008 with over 30 years of service. He is well-known for his speaking presentations on the keys to leadership.

  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.

Market Research Survey

The IMG Section is also conducting a survey on all IMG physicians to gain insights that will be helpful for the development of an IMG Toolkit to help IMGs who want to practice medicine in the U.S. or obtaining a residency.

AMA AMERICAN MEDICAL ASSOCIATION

To: Zarah Iqbal, MD, MPH

From: Hunter Pattison, MD

Date: October 23, 2019

Subject: Advisory Committee on LGBTQ Issues Update

2019 AMA INTERIM MEETING

The Advisory Committee on LGBTQ Issues (LGBTQ AC) will host its LGBTQ and Allies Caucus and Reception on Friday, November 15 at 5:00 p.m. All are welcome! The program will include keynote remarks on decriminalizing HIV by Scott Schoettes, JD. Mr. Schoettes, who lives openly with HIV, is Counsel and the HIV Project Director at Lambda Legal, the oldest national organization committed to achieving full recognition of the civil rights of LGBTQ people and everyone living with HIV through impact litigation, education and public policy work. He litigates impact cases involving discriminatory denial of employment and services based on a person's HIV status, as well as in the areas of access to care and privacy.

At noon on Saturday, June 9, LGBTQ AC members will attend the LGBTQ Health Specialty Section Council meeting and HOD Handbook review hosted by GLMA. All are welcome and encouraged to bring their own lunch.

LGBTQ MEMBERS LEAD AT OUR PARTNERS' MEETINGS

In October, the AMA sponsored an exhibit booth at the GLMA annual meeting in New Orleans. During the conference, LGBTQ AC Chair Shilpen Patel, MD joined a moderated panel on LGBTQ health policy at major medical associations. Current and past members of the LGBTQ Advisory Committee attended and/or presented. Immediate past chair Scott Chaiet, MD, MBA held a workshop on facial feminization surgery. GLMA Alternate Delegate Desi Bailey, MD led a session on LGBTQ health policy and the significant policy and advocacy outcomes as a result of the GLMA's ongoing partnership with the AMA. The AMA and the AMA Foundation also co-hosted an Ambassadors Reception for 30 joint members of AMA and GLMA, as well as members of the GLMA board of directors. Several LGBTQ AC members attend this event annually, as well as select AMA staff.

LEADERSHIP OPPORTUNITIES

The AMA Board of Trustees will soon seek nominations to fill the following roles on the LGBTQ AC for terms that will begin in June 2020:

- MSS Representative (incumbent is not eligible for another 1-year term)
- YPS Representative (incumbent is not eligible for another 3-year term)
- GLMA Representative (incumbent is not eligible for another 2-year term)

- At-Large Representatives (one incumbent is eligible for another 2-year term; another is not eligible)

LGBTQ HEALTH CURRICULUM

Several policies have been adopted by the AMA House of Delegates confirming the AMA's commitment to educate physicians and the public about LGBTQ issues in medicine, but no formal delivery method has existed to date. The LGBTQ AC is working with AMA staff to explore how to best develop a curriculum on LGBTQ health. Preliminary concepts have focused on four categories of modules, including:

1. LGBTQ Health 101 (public health perspectives, disparities, spectrum of gender, intersectionality)
2. Patient care (behavioral health, aging, STI's/HIV, reproductive health)
3. Practice transformation (SOGI data collection and management, coming out in the profession, making an office LGBTQ friendly)
4. Social determinants of health (violence, opioids, insurance, legal and policy issues, housing/homelessness)

The development of the proposed curriculum will be a primary focus of the LGBTQ AC and staff in 2020 and beyond.

LOOKING AHEAD TO 2020

LGBTQ AC members and/or AMA trustees are planning to represent the AMA and engage their professional colleagues at the following activities in 2020:

Fenway Health Institute's Advancing Excellence in Sexual and Gender Minority Health
March 20-22, 2020 | Boston, MA
** The LGBTQ AC will hold its spring meeting on March 22, in conjunction with this event. Tentative plans include a reception for local physicians and medical students who identify as LGBTQ and their allies.*

Building the Next Generation of Academic Physicians (Annual LGBTQ health workforce conference)
April 23-25, 2020 | Cornell Weill School of Medicine, NY, NY

AMA Annual Meeting
June 4-6, 2020 | Hyatt Regency Chicago

GLMA Annual Meeting
September 23-26, 2020 | Orlando, FL

AMA Interim Meeting
November 12-14 | San Diego, CA (Manchester Hyatt)

To: Zarah Iqbal, MD, MPH

From: Ashley Anderson, MD, MPH

Date: October 23, 2019

Subject: Minority Affairs Section Council Update

2019 AMA INTERIM MEETING

The Minority Affairs Section (MAS) will host its business meeting and reception on Friday, November 15 from 5:30 to 7:00 p.m. in Coronado D at the Manchester Hyatt Regency in San Diego. Light refreshments will be served. All are welcome. MAS extends a special invitation to residents and medical students who identify as under-represented in medicine, including African Americans, Latinx, and Native Americans / Alaska Natives. In addition, members of the Minority Health Policy Committee and the Workforce Diversity Committee will discuss plans for 2020 during the business meeting. (Anyone interested in joining either committee should send an email to mas@ama-assn.org. All are welcome.)

During the Annual Meeting, MAS urges members of the House of Delegates to support Resolution 910, which urges our AMA to 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.

MAS MEMBERS LEAD AT OUR PARTNERS' MEETINGS

MOLA
In October 2019, Pilar Ortega, MD lead the 3rd annual Symposium on Latinx Health at Lurie Children's Hospital and Research Center in Chicago. The event, which included 200+ attendees, was hosted by the Medical Organization for Latino Advancement, an organization for the Latinx healthcare workforce, which was founded by Dr. Ortega. AMA's Chief Health Equity Officer Aletha Maybank, MD, MPH was the lunch plenary keynote speaker. Several AMA staff also attended the event.

NMA
In July, the National Medical Association hosted its annual conference and scientific assembly in Honolulu with over 1,500 attendees. Former MAS chair Niva Lubin-Johnson, MD concluded her year as the NMA President. AMA President Patrice Harris, MD, MA offered remarks to the NMA House of Delegates during which she announced a special grant in support of NMA's 125th anniversary, which will be commemorated in Atlanta in August 2020 during their next annual conference. Drs. Harris, Lubin-Johnson, Maybank, and the ACP President Robert McLean, MD comprised a panel on addressing hypertension in the African American community. The AMA also hosted an Ambassadors Reception for members 50 joint members of AMA and NMA. Several MAS GC and section members attend this event annually, as well as select AMA staff.

AAIP
The Association of American Indian Physicians held its annual meeting in Chicago in August. Over 70 AAIP leaders held a summit at AMA Plaza to address the need for more Native Americans in medicine, which included discussions about the pipeline from STEM programs through medical school matriculation. (The number of Native American / Alaska Native physicians is less than 0.5%).

Afterwards, approximately 150 physicians, medical students and other healthcare professionals met at the Westin Hotel – West Loop Chicago. AMA presenters across the three days included Trustee Bill McDade, MD, MPH; MAS chair Siobhan Wescott, MD, MPH; MAS group manager Craig Johnson; Chief Health Equity Officer Aletha Maybank, MD, MPH; and Todd Unger, Chief Experience Officer and SVP of Marketing and Member Experience.

LEADERSHIP OPPORTUNITIES

MAS will soon announce a call for nominations to fill the following roles on its Governing Council for terms that will begin in June 2020:

- MSS Representative (incumbent is eligible for another 1-year term)
- RFS Representative (incumbent is eligible for another 2-year term)
- YPS Representative (incumbent is not eligible for another 3-year term)
- Assn. of American Indian Physicians Representative (incumbent is eligible for another 3-year term)
- National Hispanic Medical Assn. Representative (incumbent is eligible for another 2-year term)
- Delegate to the AMA House of Delegates ((incumbent is not eligible for another 3-year term)

LOOKING AHEAD TO 2020

MAS Governing Council, section members and/or AMA trustees are planning to represent the AMA and engage their professional colleagues at the following activities in 2020:

Student National Medical Association Annual Meeting
April 8-11, 2020 | Cleveland, OH Convention Center

Latino Medical Student Association Annual Meeting
April 10-11, 2020 | Washington Univ. SOM, St. Louis

National Hispanic Medical Assn. Annual Meeting
April 22-25, 2020 | Wardman Marriott Hotel, Washington, DC

National Minority Quality Forum Annual Summit on Health Disparities
April 27-29, 2020 | Watergate Hotel, Washington, DC
** MAS GC will hold its spring meeting on April 26, in conjunction with this event, which is also sponsored by the AMA as part of National Minority Health Month.*

AMA Annual Meeting
June 5-7, 2020 | Hyatt Regency Chicago

National Medical Assn. Annual Meeting
August 1-5, 2020 | Atlanta, GA

Assn. of American Indian Physicians / Assn. of Native American Medical Students Annual Meeting
August 2020 | Seattle, WA

AMA Interim Meeting
November 13-15 | San Diego, CA (Manchester Hyatt)

To: Zarah Iqbal, MD, MPH

From: Helene Nepomuceno, MD

Date: October 23, 2019

Subject: Surgical Caucus Executive Committee Update

The Surgical Caucus of the AMA exists to provide a forum at each session of the House of Delegates for discussion and recommendations concerning professional and socioeconomic issues of particular interest to surgeons. The Surgical Caucus Executive Committee consists of a Chair, Chair-Elect, Secretary, Treasurer, ACS Delegate, three Members-At-Large, and three section representatives from the OMSS, YPS, and RFS, respectively. For historical reference, a list of the prior section representatives from the RFS dating to the beginning of Executive Committee records can be found in the table below.

RFS representatives to the Surgical Caucus Executive Committee, 1999-present.

Helene Nepomuceno, MD (2019-2020)
Daisy Hassani, MD (2018-2019)
David Blitzer, MD, MBE (2017-2018)
Christopher McNicoll, MD, MPH (2016-2017)
Joshua Goldman, MD, MBA (2015-2016)
Maristella Evangelista, MD, MBA (2014-2015)
Anjali Dogra, MD (2013-2014)
Paul Kaloostian, MD (2011-2013)
SreyRam Kuy, MD (2010-2011)
Luke Brewster, MD, PhD, MA (2009-2010)
Kathryn Berndt, MD (2008-2009)
Hannah Zimmerman, MD (2007-2008)
Ross Goldberg, MD (2006-2007)
Joshua Mammen, MD (2005-2006)
Steven Hudson, MD, JD (2004-2005)
Michael Sutherland, MD (2003-2004)
David S. Geller, MD (2000-2002)
Christian S. Hinrichs, MD (2000)
Willie Underwood, MD (1998-1999)

The Surgical Caucus of the AMA celebrated its 30th anniversary in June. At the Annual HOD Meeting, the Caucus also hosted an educational session on intimate partner violence, highlighting some initiatives by the American College of Surgeons. The ACS Intimate Partner Violence Task Force has developed a toolkit, available online, on how to recognize IPV in colleagues, patients, and trainees, and how to plan for safety and get help.

During the November 2019 AMA Interim meeting, the Surgical Caucus will meet on a number of occasions, including:

1. Saturday morning 7 to 9:30 am in Coronado E for a handbook review and business meeting
2. Monday morning 10 to 11 am in Grand Hall D for a CME-accredited education session on dealing with in-flight emergencies

Students and surgical trainees are welcome to attend the Handbook Review session of the Surgical Caucus on Saturday morning and all are welcome to attend the educational session on Monday. We hope to see you there!

To: Zarah Iqbal, MD, MPH

From: Anna M. Laucis, MD, MPhil

Date: October 16, 2019

Subject: WPS Council Update

It has been a busy few months for the WPS since the annual AMA meeting. We celebrated the annual Women in Medicine month in September. You can read more about this important initiative honoring physicians who dedicate themselves to advancing women with careers in medicine at: https://www.ama-assn.org/amaone/women-medicine-month

As part of Women in Medicine Month, each year we select recipients of the Joan F. Giambalvo Fund for the Advancement of Women. We reviewed a number of highly competitive applications this year and ultimately selected two teams to receive this grant. A project led by Cara Cipriano, MD, and medical student Kate Gerull will focus on gender differences within the field of orthopaedic surgery. The second project led by Tiffany I. Leung, MD will focus on unique challenges women face as they transition from early to mid career. There are many more details about these exciting projects at: https://www.ama-assn.org/about/awards/joan-f-giambalvo-fund-advancement-women

Finally, the WPS has been active in drafting and ratifying policy in preparation for I-19. Make sure to look out for the following two HOD resolutions that have been ratified by the WPS section:

School Resource Officer Qualification and Training Qualifications

Promoting Salary Transparency among Veterans Health Administration Employed Physicians

Feel free to reach out to me anytime at anna.laucis@gmail.com so that I can best represent RFS within the WPS Governing Council.

Rules of Order: Debate Process

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

Effective April 1993
Revised January 2017

Important Points About Amendments

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

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

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

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

5. An amendment by substitution is a primary amendment.

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

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

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

Prepared by Avis McDonald, PRP

AMA-RFS 2019 Interim Meeting

LATE AND EMERGENCY RESOLUTION PROCEDURES

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

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

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

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

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

PROCEDURES

<u>Late Resolutions</u>

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

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

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

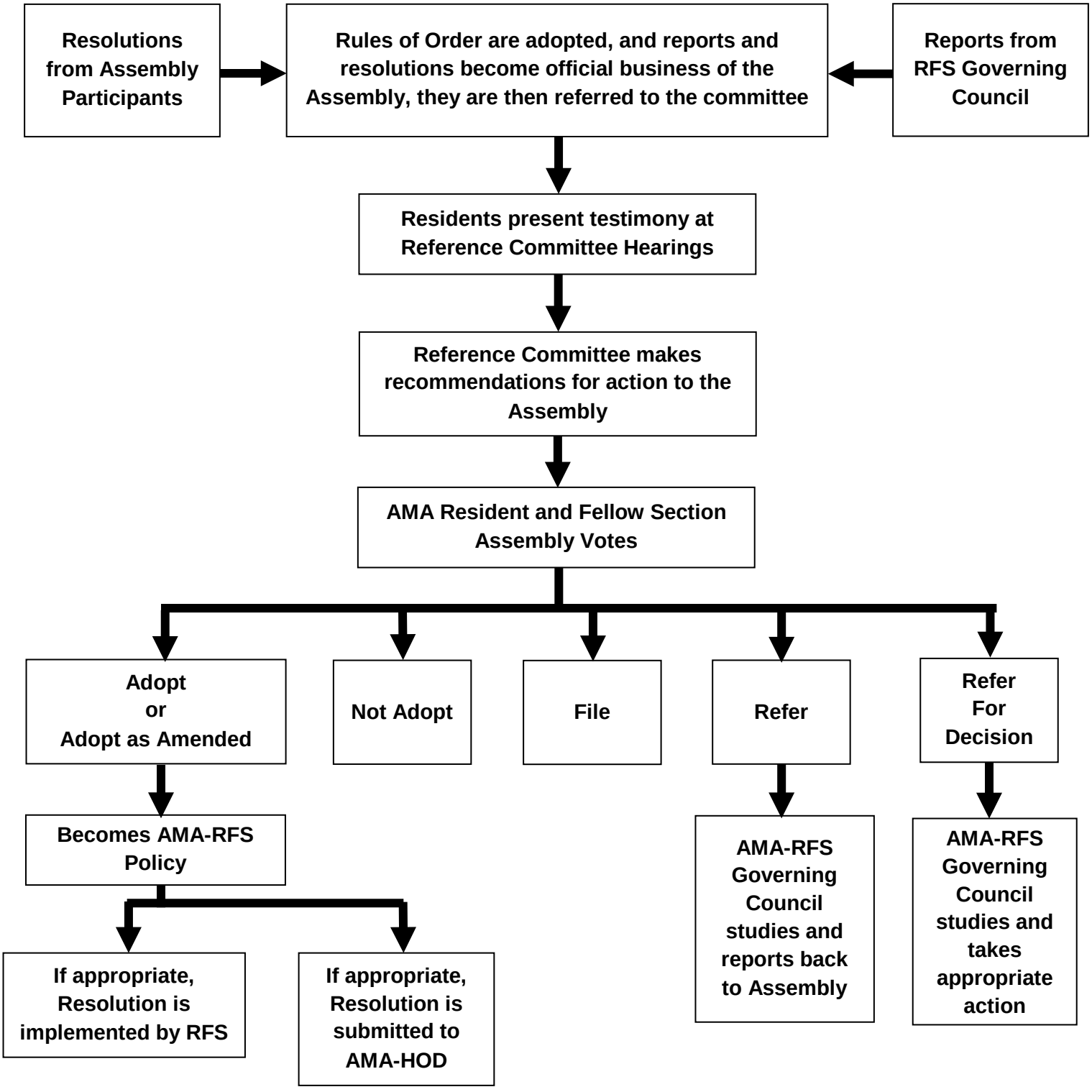
the Assembly should judge the merits of accepting the resolution on the three criteria listed above. The Assembly will then vote on whether to accept each resolution. A majority vote is required for acceptance.

Emergency Resolutions

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

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

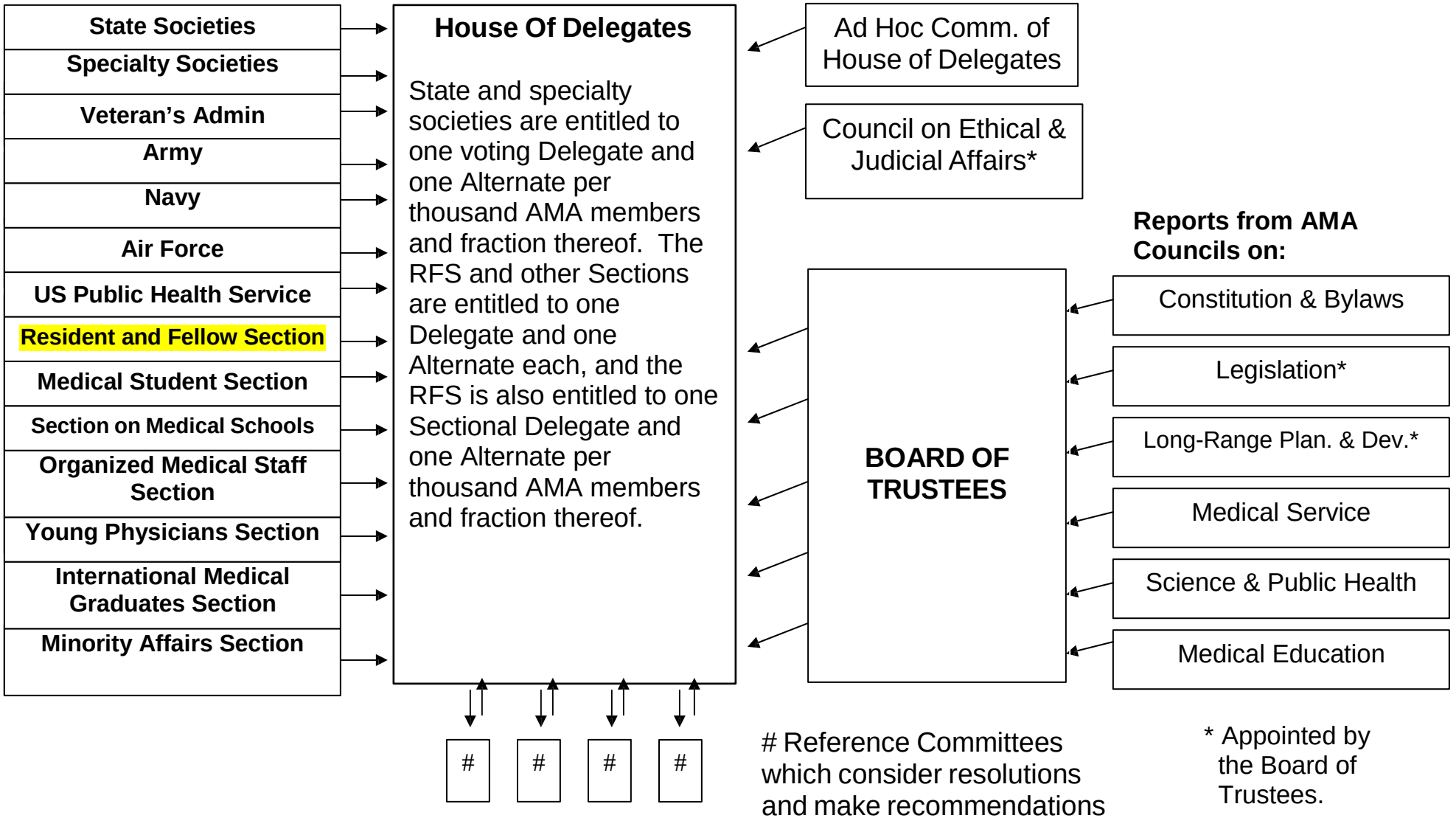
Policy Development Process



How AMA Sets Policy

Resolutions From Delegates Representing:

Input into the Meetings of the AMA House of Delegates



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

* Appointed by the Board of Trustees.

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