AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION (I-20)

Report of Reference Committee

Pratistha Koirala, MD, PhD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Report A – AMA-RFS Sunset Mechanism (2011)

2. Report B – AMA-RFS Sunset Mechanism (2008-2010)

3. Report C – Sectional Delegate Allotment

4. Report G – Facilitating Physicians in Training Seeking Mental Health Care Through Physician Health Programs

5. Report H – Pharmaceutical Advertising in Electronic Health Record Systems

6. Resolution 3 – Availability of Personal Protective Equipment (PPE)

RECOMMENDED FOR ADOPTION AS AMENDED

7. Report D – Decreasing Financial Burdens on Residents and Fellows

8. Report E – Traumatic Brain Injury and Access to Firearms

9. Resolution 4 – Support for Safe and Equitable Access to Voting

RECOMMENDED FOR ADOPTION IN LIEU OF

10. Resolution 2 – Denouncing Racial Essentialism in Medicine

11. Report F – Physician Autonomy
    Resolution 6 – Non-Physician Post-Graduate Medical Training

RECOMMENDED FOR REFERRAL

12. Resolution 1 – Resident and Fellow Work-Life Balance

RECOMMENDED FOR NOT ADOPTION

13. Resolution 5 – Research in Telemedicine Platforms for Physicians and Patients

RECOMMENDED FOR ADOPTION

(1) REPORT A – SUNSET MECHANISM 2008-2010 RFS POSITIONS

RECOMMENDATION:

Recommendation in Report A be <u>adopted</u> and the remainder of the Report be <u>filed</u>.

The Sunset Mechanism 2008-2010 RFS Positions 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internal position statements last reviewed from the RFS 2008-2010 fiscal years, as well as other relevant or associated outdated positions.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.

Your Reference Committee did not receive any testimony and recommends Report A be adopted. Of note, 292.007R Evaluations and Consultations for Use in Grievance Procedures, is recommended for recission but suggests resubmission in the future with guideline recommendations or request for a CME or joint CME/CEJA report. Your Reference Committee agrees with this recommendation as it could fill gaps in existing AMA policy (Due Process H-295.998; and Alternatives to the Federation of State Medical Boards Recommendations on Licensure H-275.934).

(2) REPORT B – SUNSET MECHANISM 2008-2010 RFS POSITIONS

RECOMMENDATION:

Recommendation in Report B be <u>adopted</u> and the remainder of the Report be <u>filed</u>.

Report B 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.

Your Reference Committee did not receive any testimony and recommends Report B be adopted.

(3) REPORT C – SECTIONAL DELEGATE ALLOTMENT

RECOMMENDATION:

Recommendation in Report C be adopted and the remainder of the Report be filed.

RECOMMENDATION:

RFS Internal Operating Procedures (IOPs)
VII. Sectional Delegates and Alternate Delegates to the House of Delegates

E. Limitations

1. There shall be a limit of ~~one~~ two Sectional Delegates and ~~one~~ two Sectional Alternate Delegates per state or specialty society in the AMA House of Delegates.

Your Reference Committee appreciates the recommendation from our current Delegate and Alternate Delegate regarding increasing Sectional Delegate allotment. Testimony was supportive and acknowledged that having only one Delegate and Alternate Delegate per state or specialty society is a barrier to participation for members of large state of specialty societies. Further, speakers noted the advantages of expanding the allotment including ensuring a more representative delegation in the HOD and retaining ample protection for smaller state and specialty societies. Therefore, your Reference Committee recommends Report C be adopted.

(4) REPORT G – FACILITATING PHYSICIANS IN TRAINING SEEKING MENTAL HEALTH CARE THROUGH PHYSICIAN HEALTH PROGRAMS

RECOMMENDATION:

Recommendations in Report G be adopted and the remainder of the Report be filed.

RECOMMENDATIONS:

Based on the report and recommendations prepared by the AMA-RFS Council on Medical Education, your AMA-RFS Governing Council recommends the following:

1) That our AMA-RFS Governing Council propose amendments (as indicated above) to the AMA Advocacy Resource Center regarding the AMA Model Bill: Physician Health Programs Act, to include changing the definition of “physicians in training” in Section 6. “Definitions” to be: (1) medical students in medical schools accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA), (2) residents in training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), or (3) fellows in ACGME or non-ACGME accredited training programs.

2) That our AMA-RFS Governing Council propose amendments (as indicated above) to the AMA Advocacy Resource Center regarding the AMA Model Bill: Physician Health Programs Act, to include changing the following subsection within the section “Application to a PHP for voluntary assistance” to read: “a physician in training who voluntarily requests participation in a PHP for a substance use disorder, mental health condition or other medical disease shall, only if they desire, have their medical school or training program involved any stage of PHP assessment, treatment planning, enrollment, and monitoring.”

3) That the AMA-RFS Governing Council report back the outcome of these actions to the AMA-RFS assembly at A-21.

Your Reference Committee heard limited but supportive testimony on Report G. Speakers emphasized the importance of expanding the definition of a trainee, as well as allowing trainees to have discretion in involving their training program at any stage of a Physician Health Program (PHP) assessment, including treatment planning, enrollment, and monitoring. It was noted that this will strengthen the model bill and further support trainees' access to and treatment through a PHP. Therefore, your Reference Committee recommends that Report G be adopted.

(5) REPORT H – PHARMACEUTICAL ADVERTISING IN ELECTRONIC HEALTH RECORD SYSTEMS

RECOMMENDATION:

Recommendation in Report H be <u>adopted</u> and the remainder of the Report be <u>filed</u>.

RECOMMENDATION:

1) That our AMA-RFS oppose medical education institutions and teaching hospitals accepting pharmaceutical and device advertising in EHRs.

Your Reference Committee heard limited testimony, all of which was in strong support of Report H. It was stated that there is no benefit to direct-to-physician advertising in Electronic Health Record (EHR) systems; if anything, it would likely lead to bias and non-evidence-based prescribing. Further, testimony raised the ethical issue of pharmaceutical companies asking institutions to pay for the elimination of such advertisements. Your Reference Committee agrees with the concerns addressed both in the report and in testimony and believes that the recommendation remedies a gap in the RFS compendium of internal position statements. Therefore, your Reference Committee recommends Report H be adopted.

(6) RESOLUTION 3 – AVAILABILITY OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

RECOMMENDATION:

Resolution 3 be <u>adopted</u>.

RESOLVED, That it is the responsibility of healthcare facilities to provide sufficient Personal Protective Equipment (PPE) for all employees and staff in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need; and be it further

RESOLVED, That our AMA supports minimum evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions; and be it further

RESOLVED, That physicians and healthcare professionals must be permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided PPE without penalty; and be it further

RESOLVED, That our AMA affirms that the medical staff of each health care institution should be meaningfully involved in disaster planning, strategy and tactical management of ongoing crises; and be it further

RESOLVED, That our AMA work with The Joint Commission, the American Nurses Credentialing Center, the Center for Medicare and Medicaid Services, and other regulatory and certifying bodies to ensure that credentialing processes for healthcare facilities include consideration of adequacy of Personal Protective Equipment (PPE) stores on hand as well as processes for rapid acquisition of additional PPE in the event of a pandemic; and be it further

RESOLVED, That the AMA study the physician's ethical duty to serve in a pandemic including but not limited to the following considerations:

1. The availability and adequacy of institutional supplied Personal Protective Equipment (PPE) and whether inadequate PPE modifies a physician's duty to act;
2. Whether a physician's duty to act is modified by the personal health of the physician and/or those with whom the physician has regular extended contact;
3. Whether a physician's duty to their personal and population safety allows them to speak with local and national media about the safety of their work environment as it relates to the risk it places on themselves, their immediate family and regular social contacts, and the public at large;
4. How medical students, residents, and fellows are affected in the setting of a pandemic in terms of their ethical obligation to care for patients, ramifications to their education, and the protections necessary given their vulnerable status;
5. The ethical obligation of healthcare institutions and the federal government to protect the physical and emotional wellbeing of physicians and other healthcare workers during and after a pandemic; and be it further

RESOLVED, That this resolution be immediately forwarded to the 2020 House of Delegates Special Meeting.

Your Reference Committee heard overwhelming support in favor of Resolution 3 as written and applauded the authors for raising critical issues of PPE shortages and the ethical considerations of medical practice during a pandemic. Limited testimony highlighted the potential unintended consequences of placing responsibility on the healthcare facilities to provide sufficient PPE especially given the complexities of operating in conjunction with government entities under a state of national emergency; however the speakers agreed on supporting the spirit of this resolution in its entirety. Your Reference Committee also agrees that immediately forwarding this resolution is warranted as the nation continues to confront PPE shortages during this unprecedented time. Therefore, your Reference Committee recommends Resolution 3 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(7) REPORT D – DECREASING FINANCIAL BURDENS ON RESIDENTS AND FELLOWS

RECOMMENDATION A:

Recommendation 1 of Report D be amended by addition and deletion to read as follows:

1. That our AMA work with ACGME, AAMC, and other relevant stakeholders to advocate that medical trainees not be required to pay for essential amenities ~~including, but not limited to on-site parking, scrubs, and white coats.~~ and/or high cost or safety-related, specialty-specific equipment required to perform clinical duties.

RECOMMENDATION B:

Report D be adopted as amended.

RECOMMENDATIONS:

Based on the recent FREIDA expansion, and based on the report and recommendations prepared by the AMA-RFS Committee on Long Range Planning, your AMA-RFS Governing Council recommends that the following be adopted in lieu of GC Report F (A-19) and the remainder of the report be filed:

1) That our AMA work with ACGME, AAMC, and other relevant stakeholders to advocate that medical trainees not be required to pay for essential amenities including, but not limited to on-site parking, scrubs, and white coats.
2) That our AMA work with relevant stakeholders including the AAMC to define "access to food" for medical trainees to include 24-hour access to fresh food and healthy meal options within all training hospitals.
3) That our AMA work with relevant stakeholders to ensure that medical trainees have access to on-site and subsidized childcare.
4) That the Residents and Fellows' Bill of Rights be prominently published online on the AMA website and be disseminated to residency and fellowship programs.
5) That the Residents and Fellows' Bill of Rights (H-310.912) be amended by addition and deletion to read as follows:

5. Our AMA partner with ACGME and other relevant stakeholders to encourage~~s~~ training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and child care services. ~~teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation.~~

Your Reference Committee heard unanimous testimony favoring the spirit of this Report; however, an amendment was offered to the first recommendation adding examples of high-cost, specialty specific equipment to the already prescriptive list of essential amenities. Further testimony supported the amendment but suggested broadening its entire ask to allow for more general applicability to all trainees. Speakers also expressed reservations concerning the specificity of the original list as it may have unintended consequences of putting the onus on residents and fellows to cover the cost of their own garments and equipment.

Your Reference Committee agrees with the proposed revisions to the amendment expanding its applicability and preserving the durability of the ask to include all specialties and their corresponding equipment needs which inevitably will evolve over time. Therefore, your Reference Committee recommends adopting Report D as amended.

(8) REPORT E – TRAUMATIC BRAIN INJURY AND ACCESS TO FIREARMS

RECOMMENDATION A:

Recommendation 2 of Report E be amended by addition and deletion to read as follows:

2. That our AMA amend policy H-145.975 "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care" by addition and deletion to read as follows:

…2. Our AMA supports initiatives designed to enhance access to the comprehensive assessment and treatment of mental health and substance use disorders in patients with ~~cognitive health care, with greater focus on the diagnosis and management of~~ traumatic brain injury~~y~~ies. ~~mental illness and concurrent substance use disorders,~~. ~~and~~

3. Our AMA work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to evaluate the risk of potential violent behavior in patients with traumatic brain injury~~y~~ies. ~~and mental health assessment for potential violent behavior.~~

~~3.~~ 4. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

RECOMMENDATION B:

Report E be adopted as amended.

RECOMMENDATIONS:

1) That our AMA reaffirm policy H-145.972 "Firearms and High-Risk Individuals."

2) That our AMA amend policy H-145.975 "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care" by addition to read as follows:

…2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of traumatic brain injury, mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to traumatic brain injury and mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

Your Reference Committee commends the work of the 2019-2020 Committee on Public Health for their work on Report E, as well as the authors of the original resolution (RFS Res. 1-A-19) for bringing this important issue to the attention of the Assembly. Your Reference Committee heard limited but supportive testimony offering an amendment to H-145.975 in order to accurately reflect clinical terminology and clarify the fact that clinicians are only able to assess for "potentially violent behavior" and not "potential violence." Your Reference Committee believes the above amended language significantly improves current policy to reflect accurate industry standard language and treatment modalities. Therefore, your Reference Committee recommends that Report E be adopted as amended.

(9) RESOLUTION 4 – SUPPORT FOR SAFE AND EQUITABLE ACCESS TO VOTING

RECOMMENDATION A:

Resolve 1 of Resolution 4 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support measures to facilitate safe and equitable access to voting ~~reduce crowding at polling locations~~ as a harm-reduction strategy ~~and facilitate equitable access to voting as a means~~ to safeguard public health and mitigate unnecessary risk of infectious disease transmission; ~~to immunocompromised groups, including:~~

~~(a) extending polling hours;~~
~~(b) increasing the number of polling locations;~~
~~(c) extending early voting periods;~~
~~(d) mail-in ballot postage that is free or prepaid by the government;~~
~~(e) adequate resourcing of the United States Postal Service and election operational procedures;~~
~~(f) improve access to drop off locations for mail-in or early ballots; and~~
~~(g) stipulating that ballots postmarked by Election Day must be counted;~~ and be it further

RECOMMENDATION B:

Resolution 4 be adopted as amended.

RESOLVED, That our AMA support measures to reduce crowding at polling locations and facilitate equitable access to voting as a means to safeguard public health and mitigate unnecessary risk to immunocompromised groups, including:

(a) extending polling hours;
(b) increasing the number of polling locations;
(c) extending early voting periods;
(d) mail-in ballot postage that is free or prepaid by the government;
(e) adequate resourcing of the United States Postal Service and election operational procedures;
(f) improve access to drop off locations for mail-in or early ballots; and
(g) stipulating that ballots postmarked by Election Day must be counted; and be it further

RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail; and be it further

RESOLVED, That this resolution be immediately forwarded to the November 2020 House of Delegates Special Meeting.

Your Reference Committee heard unanimous testimony regarding the importance of this resolution attempting to strike a balance between safeguarding public health and maximizing

civic engagement. Speakers strongly supported the AMA taking an active stance on safe and equitable voting protections, whose vulnerabilities were exacerbated by the COVID-19 pandemic; however there was mixed testimony on both its scope and timeliness. Several friendly amendments were offered with the intent of increasing the durability and inclusivity of the resolved clauses, but a consensus was not reached regarding the need to immediately forward this resolution.

Your Reference Committee agrees with the value of broadening the resolution to include risks to voters beyond only immunocompromised populations and allowing for advocacy on other social and financial issues in order to mitigate voting inequities. While your Reference Committee acknowledges that this resolution will be heard after the 2020 general election, it agrees that significant state and local elections will continue to occur in Spring 2021 prior to the June 2021 Annual Meeting. Many of these state and local elections will have a direct impact on the public health response to the ongoing pandemic and as a result, immediate forwarding is warranted. Therefore, your Reference Committee recommends Resolution 4 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(10) RESOLUTION 2 - DENOUNCING RACIAL ESSENTIALISM IN MEDICINE

RECOMMENDATION:

Alternate Resolution 2 be adopted in lieu of Resolution 2.

DENOUNCING RACIAL ESSENTIALISM IN MEDICINE

RESOLVED, That out AMA-RFS recognizes that race is a social construct rather than an inherent biological or genetic trait, and their false conflation can lead to inadequate examination of true underlying risk factors; and be further

RESOLVED, That our AMA-RFS recognizes that structural racism exists in the American healthcare system and that it is a systemic and public health crisis; and be it further

RESOLVED, That our AMA-RFS acknowledge that there may be inherent biologic and genetic traits, distinct from race, linked to certain diseases and that these should be studied and appropriately factored into risk algorithms, screening, and treatment; and be it further

RESOLVED, That out AMA-RFS encourages appropriate stakeholders to eliminate racial essentialism from clinical algorithms in an evidence-based fashion; and be it further

RESOLVED, That our AMA-RFS encourages appropriate stakeholders to eliminate racial essentialism in medical education curricula and board examinations.

RESOLVED, That our AMA recognizes that the false conflation of race with inherent biological or genetic traits leads to inadequate examination of true underlying disease risk factors, which exacerbates existing health inequities; and be it further

RESOLVED, That our AMA encourages characterizing race as a social construct, rather than an inherent biological trait, and recognizes that when race is described as a risk factor, it is more likely to be a proxy for influences including structural racism than a proxy for genetics; and be it further

RESOLVED, That our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME, other appropriate stakeholder organizations, and content experts to identify and address aspects of medical education and board examinations which may be perpetuating the mistaken belief that race is an inherent biologic risk factor for diseases; and be it further

RESOLVED, That our AMA will collaborate with appropriate stakeholders and content experts to develop recommendations on how to interpret or improve clinical algorithms that currently include race-based correction factors; and be it further

RESOLVED, That this resolution be immediately forwarded to the November 2020 House of Delegates Special Meeting.

Your Reference Committee heard mixed testimony on Resolution 2. While there was nearly unanimous support for the spirit of the resolution, there was some opposition to accepting the language as written. Friendly amendments were offered primarily suggesting that the AMA conduct further studies before policy is codified on this issue, but others felt the resolution was thorough, well-researched, and that studies would delay the AMA from addressing this topic in a timely fashion.

Finally, debate was heard as to whether this resolution meets the urgency threshold for the November 2020 House of Delegates (HOD) Special Meeting. It is important to note that two similar resolutions already submitted to the HOD have been deemed to meet the criteria of consideration. Resolution 010 presents nearly identical language to this resolution, while Resolution 011 offers related language addressing the elimination of race as a proxy for ancestry, genetics, and biology in medical education, research, and clinical practice.

Your Reference Committee believes that it is important for the AMA to be the leading voice in combating these critical issues and therefore recommends adopting Alternate Resolution 2 in lieu of Resolution 2, encompassing the original intent of the authors while also allowing the RFS to support both Resolutions 010 and 011 in the HOD with its internal position statements.

(11) REPORT F – PHYSICIAN AUTONOMY
RESOLUTION 6 – NON-PHYSICIAN POST-GRADUATE MEDICAL TRAINING

RECOMMENDATION:

Alternate Resolution 6 be <u>adopted in lieu of the recommendations of Report F and Resolution 6</u> and the remainder of Report F <u>be filed</u>.

RESOLVED, That our AMA supports pay equity among trainees within the healthcare team and believes that salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence allowed by an individual's training program; and be it further

RESOLVED, That our AMA amend policy H-275.925 "Protection of the Titles "Doctor," "Resident" and "Residency" by addition and deletion to read as follows:

Our AMA:

(1) recognizes that the terms "medical student," "resident," "residency," "fellow," "fellowship," "doctor," and "attending," when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians, thus these terms should be reserved to describe physician role; ~~(1)~~ (2) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; ~~(2)~~ (3) supports state legislation that would penalize misrepresentation of one's role in the physician-led healthcare team, up to and including to make it a felony to misrepresent oneself as a physician (MD/DO)~~.~~; and (4) supports state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training programs using the terms "medical student", "resident", "residency", "fellow", "fellowship", "doctor", or "attending" in a healthcare setting.; and be it further

RESOLVED, That our AMA amend policy H-160.949, "Practicing Medicine by Non-Physicians" by addition to read as follows:

…(7) support Nurse Practitioners and Physician Assistants pursuing postgraduate clinical training prior to working within a subspecialty field.; and be it further

RESOLVED, That our AMA study curriculum and accreditation requirements for graduate and postgraduate clinical training programs for non-physicians and report back at A-22 and biennially thereafter, on these standards, their accreditation bodies, their supervising boards, and the impact of non-physician graduate clinical education on physician graduate medical education; and be it further

RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians do not divert funding from physician GME; and be it further

RESOLVED, That our AMA partner with the ACGME to create standards requiring Program Directors and Designated Institutional Officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships; and be it further

RESOLVED, That policy H-310.912 "Resident and Fellow Bill of Rights" be amended by addition and deletion to read as follows:

> **…B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.**
>
> **With regard to supervision, residents and fellows must be ultimately supervised by physicians. ~~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. In instances where education is provided by non-physicians there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate non-physician supervision to the training program, sponsoring institution, or ACGME as appropriate. ~~It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.~~; and be it further**

RESOLVED, That our AMA will distribute and promote the *Residents and Fellows' Bill of Rights* online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles; and be it further

RESOLVED, That this resolution be immediately forwarded for consideration at the November 2020 Special Meeting of the House of Delegates.

Report F
That our AMA-RFS support equivalent or better reimbursement between physicians in training and midlevel providers at equal postgraduate training levels, and that these payments account for the level of complexity of care provided, workload and number of hours worked.

That our AMA-RFS support the restriction of the terms “residency” and “fellowship” to refer specifically to physicians-in-training.

That our AMA-RFS oppose: a) caps to GME funding for physicians-in training; and b) diversion of GME funding for midlevel training positions.

That our AMA-RFS support reducing administrative burden for physicians-in-training.

That our AMA-RFS reaffirm position statement 170.011R “Investigation into Residents, Fellows, and Physician Unions.”

That our AMA reaffirm policy H-160.912.

That our AMA reaffirm policy D-383.996.

That our AMA amend the *Residents and Fellows’ Bill of Rights* (H-310.912) by addition to read as follows:

> 8. Our AMA will distribute and promote the *Residents and Fellows’ Bill of Rights* online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

That our AMA study the curriculum and accreditation requirements for midlevel provider programs and make recommendations for scope of practice legislation with report back by A-22.

Resolution 6

RESOLVED, that our AMA support Nurse Practitioners (NPs) and Physician Assistants (PAs) pursuing post-graduate clinical training prior to practicing within a subspecialty; and be it further

RESOLVED, That our AMA supports pay equity among trainees within the healthcare team and believes that salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence allowed by an individual’s training program; and be it further

RESOLVED, That our AMA recognize that the terms “medical student,” “resident,” “residency,” “fellow,” “fellowship,” “doctor,” and “attending,” when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians, and thus these terms should be reserved to describe physician roles; and be it further

RESOLVED, That our AMA amend policy H-275.925 “Protection of the Titles "Doctor," "Resident" and "Residency" by addition as follows:

> Our AMA: (1) will advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; (2) supports state legislation that would penalize misrepresentation of one’s role in the physician-led healthcare team, up to and including to make it a felony to misrepresent oneself as a physician (MD/DO);

and (3) supports state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training programs using the terms “medical student”, “resident”, “residency”, “fellow”, “fellowship”, “doctor”, or “attending” in a healthcare setting.; and be it further

RESOLVED, That policy H-310.912 “Resident and Fellow Bill of Rights” be amended by addition and deletion to read as follows:

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

With regard to supervision, all physicians in graduate medical education must be ultimately supervised only by physicians. 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. In instances where physicians are immediately supervised by non-physicians there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate non-physician supervision to the training program, sponsoring institution, or ACGME as appropriate. ~~It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.~~; and be it further

RESOLVED, That our AMA work with relevant stakeholders to define appropriate labels for post-graduate clinical and diagnostic training programs for non-physicians that recognizes the rigor of these programs but prevents role confusion associated with the terms “resident”, “residency”, “fellow”, or “fellowship” and report back on the progress of this initiative by I-21; and be it further

RESOLVED, That our AMA partner with the ACGME to create standards requiring Program Directors and Designated Institutional Officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships; and be it further

RESOLVED, That our AMA study curriculum and accreditation requirements for postgraduate clinical training programs for non-physicians and report back at I-21 and biennially thereafter, on these standards, their accreditation bodies, their supervising boards, and the impact of non-physician graduate clinical education on physician graduate medical education; and be it further

RESOLVED, That our AMA study the current regulating, licensing, and certifying bodies governing Nurse Practitioners, Physicians Assistants, Certified Registered Nurse Anesthetists, and Anesthesia Assistants, including their geographic practice patterns; and be it further

RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians does not divert funding from physician GME; and be it further

RESOLVED, That our AMA object to the ABMS and its member boards having designated seats for Nurse Practitioners, Physicians Assistants, Certified Registered Nurse Anesthetists, or Anesthesia Assistants that are independent from the public member seats; and be it further

RESOLVED, That the above resolved clauses be immediately forwarded to the November 2020 House of Delegates Special Meeting; and be it further

RESOLVED, That AMA-RFS policy 380.002R ("Independent Practice of Medicine") be amended by addition and deletion to read as follows:

That our AMA-RFS support: (1) working at the local, state, and federal levels of government, through both legislation and regulation, to prevent the independent practice of medicine by non-physicians; mid-level health care providers, as medicine should only be practiced by a fully licensed physician qualified by reason of education, training, and experience in such practice; and (2) reimbursement models that working toward regulation and legislation that create reimbursement models do not reimburse non-physicians mid-level providers at the same rates as physicians, and (3) legislation requiring all healthcare providers to clearly identify their credentials to patients, including specifically identifying whether or not they are a physician.; and be it further

RESOLVED, That our AMA-RFS rescind policies 40.002R ("Mid-Level Practitioner Tracking System), 380.003R ("Proper identification of Health Care Providers"), and 380.004R ("Scope of Practice of Mid-Level Providers").

Your Reference Committee heard limited but supportive testimony on Report F. Speakers commended the Committee on Legislation and Advocacy for bringing forth a well-written comprehensive report on the adverse impact of non-physician scope of practice expansion on physician autonomy; however, Speakers noted that while Recommendations 1-5 focus on trainees, the issue is extremely critical, timely, and should be brought to the HOD to codify as AMA policy. Testimony also pointed out that Recommendation 5, asking for reaffirmation of RFS position statement 170.011R, is outmoded because it was codified at A-19 as D-383.977, from which a study is still pending.

Your Reference Committee heard extensive testimony in support of Resolution 6. Both the authors and speakers set out to address the following concerns: 1) pay equity between NPs/PAs in "residencies" and physician residents at the same institution; 2) misuse of the titles for physicians-in-training for APPs undergoing "residency" training; 3) the potential (and detrimental) reallocation of CMS GME funding to pay for APP residency positions; 4) the potential supervision of physicians-in-training by non-physicians; and 5) the loss of learning opportunities for physicians-in-training who are displaced by APPs in "residency" training.

Testimony was mixed on Resolve clauses 7, 11, and 14. The consensus was that these statements seemed out of place when compared to the overarching objective of the resolution and/or have already been accomplished. In Resolve clause 7, the authors call for a reporting mechanism between Program Directors and the ACGME when trainee displacement due to APP "residencies" occur. Your Reference Committee wishes to note that such anonymous reporting mechanisms are currently in place to report complaints about training programs, including preferential treatment to non-physicians. Further, Resolve clause 11 asks the ABMS to prohibit APPs from serving on their Board in public member seats, but this is already current practice. Finally, Resolve clause 14 asks to rescind several existing RFS position statements

on mid-level practice and identification. Speakers emphasized the fact that these position statements still hold internal value and do not need to be rescinded.

Your Reference Committee gave significant thought to the authors' goals behind both Report F and Resolution 6. Given their stark similarities, your Reference Committee recommends Alternate Resolution 6 be adopted as it represents an amalgam of the strongest, most actionable asks substantiated by ample testimony. Furthermore, your Reference Committee believes immediately forwarding Alternate Resolution 6 is warranted since it would bolster the AMA's ongoing advocacy efforts on scope of practice issues in upcoming state and federal legislative sessions in Spring 2021.

RECOMMENDED FOR REFERRAL

(12) RESOLUTION 1 – RESIDENT AND FELLOW PHYSICIAN WORK-LIFE BALANCE

RECOMMENDATION:

Resolution 1 be <u>referred</u>.

RESOLVED, That our American Medical Association advocate for resident and fellow trainees to be regularly given separately allotted protected time dedicated for mental health, rather than the current practice of sharing “personal days” with illness, other health-related appointments, family emergencies, and interviews; so that trainees can participate in elective stigma-free mental health and substance use disorder services, in order to maximize work-life balance; and be it further

RESOLVED, That our AMA support governing bodies, including ACGME, in developing and expanding on formal policy and standards aimed at protecting resident and fellow trainees’ well-being, including professionally, physically, psychologically, and socially, during the course of their training.

Your Reference Committee heard predominantly supportive testimony of the spirit of the resolution, but called for referral to return more actionable, evidence-based recommendations on the effect of protected time on the mental health of trainees. Significant concerns were raised surrounding parity of time off for physical and mental health care, the risk of increased stigma should they be formally separated, and the conflation of poor work-life balance with mental illness.

Your Reference Committee agrees that the RFS would benefit from further study of this issue, including but not limited to: (a) a better understanding of how different specialties and programs approach personal time off; (b) the importance of differentiating formal mental health evaluation and treatment with time to preserve one's mental health in coordination with an understanding of Section VI.C.1.d.(1) of the ACGME Common Program Requirements; (c) the projected impact of protected mental health time on combating burnout/wellness; and (d) the potential unintended consequences of increasing coworker workloads and decreasing the quality/continuity of patient care and trainee education.

RECOMMENDED FOR NOT ADOPTION

(13) RESOLUTION 5 – RESEARCH IN TELEMEDICINE PLATFORMS FOR PHYSICIANS AND PATIENTS

RECOMMENDATION:

Resolution 5 <u>not be adopted</u>.

RESOLVED, That our AMA advocate for studies that provide analysis on the access of telemedicine for patients; and be it further

RESOLVED, That our AMA advocate for further study in the efficacy of different telemedicine platforms; and be it further

RESOLVED, That our AMA advocate for policy and measures that make telemedicine a more broadly available tool in the healthcare system for patients, when feasible.

Your Reference Committee heard overwhelming opposition to Resolution 5 as written. While the spirit of the resolution was commended, especially in light of COVID-19's catalyzing the expanded use telemedicine, Speakers highlighted the significant body of existing AMA policy on the issue as well as a plethora of current research taking place, including by the AMA who is currently working in collaboration with patient-focused industry leaders such as JD Power and the COVID-19 Healthcare Coalition Telehealth Workgroup spearheaded by Mayo and MITRE.

While limited testimony suggested a weakness in AMA policy with regard to access and amendments were offered, it should be noted that Res. 203 "COVID–19 Emergency and Expanded Telemedicine Regulations" will be heard at the 2020 Special Meeting of the House of Delegates. It asks, in part, "That our AMA advocate that the current emergency regulations for improved access to and payment for telemedicine services be made permanent with respect to payment parity and use of commonly accessible devices for connecting physicians and patients…" Furthermore, D-480.968(4) states that "Our AMA will educate and advocate to AMA members on the use and implementation of telemedicine and other related technology in their practices to improve access, convenience, and continuity of care for their patients."

At this juncture, your Reference Committee believes the AMA is currently at the forefront of research and advocacy on telemedicine and this resolution would be duplicative of those efforts. Therefore, your Reference Committee recommends that Resolution 5 not be adopted.

Pratistha Koirala, MD, PhD, Chair

David Savage, MD, PhD

Karen Dionesotes, MD, MPH

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Gregory de Gruchy, MD