AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION (A-21)

Report of Reference Committee

Amar Kelkar, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 1 – Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use

2. Resolution 16 – Accountable Organizations to Resident and Fellow Trainees

RECOMMENDED FOR ADOPTION AS AMENDED

3. Report A – The Effect of the COVID-19 Pandemic on Graduate Medical Education

4. Report B – Improving Access to Physician Health Programs for Physician Trainees

5. Report C – "Residents' and Fellows' Bill of Rights" Update

6. Resolution 2 – Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent

7. Resolution 6 – Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers

8. Resolution 7 – Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care

9. Resolution 9 – The Impact of Private Equity on Medical Training

10. Resolution 10 – Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGS

11. Resolution 13 – COVID-19 Vaccination Rollout to Emergency Departments and Urgent Cares

12. Resolution 15 – Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

RECOMMENDED FOR ADOPTION IN LIEU OF

13. Resolution 4 – Opposition to Mid-level Provider Bias Against Physicians and Physician-Led Care

Resolution 5 – Non-Physician Continued Education, Specialty and Subspecialty Training

14. Resolution 12 – Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer

15. Resolution 14 – Expanding the AMA's Study on the Economic Impact of COVID-19

RECOMMENDED FOR REFERRAL

16. Resolution 11 – Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education

RECOMMENDED FOR NOT ADOPTION

17. Resolution 3 – Title Change to HOD Policy D-383.996 "Impact of the NLRB Ruling in the Boston Medical Center Case"

18. Resolution 8 – Revising the CMS Definition of "Physician"

19. Resolution 17 – Residency Program Social Media Presence to Increase Information Available to Applicants

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 1 – GONAD SHIELDS: REGULATORY AND LEGISLATION ADVOCACY TO OPPOSE ROUTINE USE

RECOMMENDATION:

Resolution 1 be adopted.

RFS ACTION: Resolution 1 adopted.

RESOLVED, That our AMA oppose mandatory use of gonad shields in medical imaging considering the risks far outweigh the benefits; and be it further

RESOLVED, That our AMA advocate that the FDA amend the code of federal regulations to oppose the routine use of gonad shields in medical imaging; and be it further

RESOLVED, That our AMA, in conjunction with state medical societies, support model state and national legislation to oppose or repeal mandatory use of gonad shields in medical imaging.

Your Reference Committee heard only supportive testimony of Resolution 1, and while we feel that such a resolution may be more appropriate coming through a specialty society, we applaud the authors for their passion and advocacy on this topic and recommend adoption. Additionally, your Reference Committee questions the necessity of the third resolved clause, given that repealing the use of gonad shields can be made through changes to local, state, and federal regulations, thus, model legislation would not be necessary. However, given the lack of testimony to this last point, we elected to retain this resolved clause. Therefore, your Reference Committee recommends that Resolution 1 be adopted.

(2) RESOLUTION 16 – ACCOUNTABLE ORGANIZATIONS TO RESIDENT AND FELLOW TRAINEES

RECOMMENDATION:

Resolution 16 be adopted.

RFS ACTION: Resolution 16 adopted.

RESOLVED, That our AMA work with relevant stakeholders to: (1) determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests; (2) determine how organizations can be held accountable for fulfilling their duties to protect the rights and wellbeing of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights; (3) determine methods of advocating for residents and fellows that are timely and effective without jeopardizing trainees' current and future employability; (4) study and report back by A-22 on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and (5) determine transparent methods to communicate available residency positions to displaced residents.

1 Your Reference Committee heard only supportive testimony regarding this resolution calling
2 for a study by the AMA to determine the best way to build an Accountable Organization for
3 Resident and Fellow Trainees. Given the complexity of this topic, the study called for by this
4 resolution will allow our AMA to consider the many intertwined interests including finance,
5 health & safety, employment benefits, and professional education, and make thoughtful
6 recommendations on how to address this chronic issue for trainees, including defining the
7 scope of responsibility of those organizations who are already engaged, identifying specific
8 gaps, and planning how to best address them. Therefore, your Reference Committee
9 recommends that Resolution 16 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(3) REPORT A – THE EFFECT OF THE COVID-19 PANDEMIC ON GRADUATE MEDICAL EDUCATION

RECOMMENDATION A:

Report A be amended by addition to read as follows:

4. That this resolution be immediately forwarded to the AMA House of Delegates at the June 2021 Special Meeting of the HOD.

RECOMMENDATION B:

Report A be adopted as amended and the remainder of the report be filed.

RFS ACTION: Recommendations in Report A adopted as amended and the remainder of the Report filed.

RECOMMENDATIONS:

Based on the report prepared by the RFS Committees on Education and Quality and Patient Safety, your RFS Governing Council recommends the following:

1. That our AMA work with the ACGME and other relevant stakeholders to provide additional benefits for compensation, such as moonlighting, hazard pay, and/or additional certifications for residents and fellows who are redeployed to fulfill service needs that are outside the scope of their specialty training.

2. That our AMA urge ACGME to work with relevant stakeholders including residency and fellowship programs to ensure each graduating resident or fellow is provided with documentation explicitly stating his/her board eligibility and identifying areas of training that have been impacted by COVID-19 that can be presented to the respective board certifying committee.

3. That our AMA urge ACGME and specialty boards to consider replacing minimums on case numbers and clinic visits with more holistic measures to indicate readiness for graduation and board certification eligibility, especially given the drastic educational barriers confronted during the COVID-19 pandemic.

Your Reference Committee heard limited, but unanimous testimony supporting this Report. Of note, testimony highlighted that prior RFS Governing Council advocacy resulted in the publication of the "Guiding principles to protect resident & fellow physicians responding to COVID-19" on the AMA website and recommended immediate forwarding to the AMA House of Delegates due to timeliness of the issue and importance of AMA advocacy to the ACGME, despite the challenges of obtaining approval from the Resolution Committee.

According to the Report, most specialty boards have left case numbers and other quotas to the determination of individual programs, which will result in incongruent impact on trainees. Your Reference Committee agrees with testimony recommending immediate forwarding, given the timeliness of this Report, as current graduating trainees will not have adequate time to advocate to specialty boards and ACGME. Therefore, your Reference Committee recommends that Report A be adopted as amended and the remainder of the report be filed.

(4) REPORT B – IMPROVING ACCESS TO PHYSICIAN HEALTH PROGRAMS FOR PHYSICIAN TRAINEES

RECOMMENDATION A:

Report B be amended by addition and deletion to read as follows:

~~1. That our AMA amend AMA Model Bill: Physician Health Programs Act, Section 4 by addition to read as follows:~~

> **~~(3) The AMA supports the early detection, evaluation and treatment of licensed physicians, physicians in training, and other licensed healthcare professionals suffering from a substance use disorder, mental health condition, or other medical disease or potentially impairing conditions. Appropriate evaluation and treatment of these physicians at programs experienced with the treatment of professionals in a safety sensitive environment will ultimately enhance the health of the provider and better protect the public~~**

~~2. That our AMA amend AMA Model Bill: Physician Health Programs Act, Section 6 by addition and deletion to read as follows:~~

> **~~(h) "Participant" shall mean a licensed physician, physician in training, or other licensed health care professional or those in training enrolled in a PHP pursuant to an agreement between the health care professional and the PHP.~~**

~~3. That our AMA support the widespread use of physician health programs by physicians in training including residents and fellows in ACGME and AOA accredited training programs; and be it further~~

~~4.~~ 1. That our AMA work with the ACGME~~, AOA,~~ and other relevant stakeholders to ensure physician health programs (PHPs) are promoted by training programs

and transparent information is disseminated by programs to their trainees about PHP reporting requirements, benefits of participation, and limitations of such programs; and be it further

~~5~~ 2. That our AMA recognize PHPs ~~physician health programs~~ as one of many resources available to support physician trainee mental health.

RECOMMENDATION B:

Report B be adopted as amended and the remainder of the report be filed.

RFS ACTION: Recommendations in Report B adopted as amended and the remainder of the Report filed.

RECOMMENDATIONS:

Based on the report and recommendations prepared by the AMA-RFS Committee on Legislation and Advocacy, your AMA-RFS Governing Council recommends the following:

1. That our AMA amend AMA Model Bill: Physician Health Programs Act, Section 4 by addition to read as follows:

   (3) The AMA supports the early detection, evaluation and treatment of licensed physicians, physicians in training, and other licensed healthcare professionals suffering from a substance use disorder, mental health condition, or other medical disease or potentially impairing conditions. Appropriate evaluation and treatment of these physicians at programs experienced with the treatment of professionals in a safety sensitive environment will ultimately enhance the health of the provider and better protect the public."

2. That our AMA amend AMA Model Bill: Physician Health Programs Act, Section 6 by addition and deletion to read as follows:

   (h) "Participant" shall mean a licensed physician, physician in training, or other licensed health care professional ~~or those in training~~ enrolled in a PHP pursuant to an agreement between the health care professional and the PHP.

3. That our AMA support the widespread use of physician health programs by physicians in training including residents and fellows in ACGME and AOA accredited training programs; and be it further

4. That our AMA work with the ACGME, AOA, and other relevant stakeholders to ensure physician health programs are promoted by training programs and transparent information is disseminated by programs to their trainees about PHP reporting requirements, benefits of participation, and limitations of such programs; and be it further

5. That our AMA recognize physician health programs as one of many resources available to support physician trainee mental health.

Your Reference Committee heard supportive testimony with calls for amendments. Overall, your Reference Committee appreciates the importance of increased access to physician health programs for physician trainees, however, offers the following approach. Your Reference Committee acknowledges that the AMA House of Delegates is not the correct forum to recommend changes to AMA Model Bills, and that this ask would be better carried out through the AMA Advocacy Resource Center. For this reason, your Reference Committee recommends striking the first and second recommendations from this report. Additionally, your Reference Committee recommends striking the third recommendation, as this is carried out by the fourth and fifth recommendations. Finally, your reference committee recommends striking the word "AOA" from the fourth recommendation, as the American Osteopathic Association no longer accredits residency programs. Therefore, your Reference Committee recommends that Report B be adopted as amended and the remainder of the report be filed.

(5) REPORT C – "RESIDENTS' AND FELLOWS' BILL OF RIGHTS" UPDATE

RECOMMENDATION A:

Recommendation 1.E(1)c of Report C be amended by addition to read as follows:

…E. ;and c. Recognition as full-time workers and a right to unionize, granting residents and fellows the ability to advocate collectively to employers and lawmakers on behalf of patients and themselves as workers, not only as learners.

RECOMMENDATION B:

Report C be adopted as amended and the remainder of the report be filed.

RFS ACTION: Recommendations in Report C adopted as amended and the remainder of the Report filed.

RECOMMENDATIONS:

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

1. That our AMA-RFS amend the Residents' and Fellows' Bill of Rights by addition and deletion to read as follows:

291.009R Resident and Fellow Bill of Rights:
That our AMA-RFS support: 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 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~~,~~ including but not limited to membership to medical libraries, remote access to medical journals, and other online or mobile resources; ~~and~~ (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings~~.~~; (6) Financial support or reimbursement for board certification, medical licensing examinations (such as the USMLE STEP 3 or specialty-specific testing), and educational conferences, to reduce the financial burden residents and fellows face; and (7) Opportunities to advance career development, such as access to leadership roles on hospital committees and adequate paid time off for job and fellowship interviews.

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.

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~~.~~; and c. Recognition as full-time workers and a right to unionize, granting residents and fellows to advocate collectively to employers and lawmakers on behalf of patients and themselves as workers, not only as learners.
(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 enable trainees to support their families and pay educational debts, 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 and differences based on geographical location.
(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 without pressure to leave it unused or penalization for its use; 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~~.~~; and (3) Adequate hospital staffing and support, including the maintenance of back-up call schedules for every residency program.

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.

2. That our AMA-RFS review and update the Residents' and Fellows' Bill of Rights at a minimum every ten years.

Your Reference Committee heard unanimous supportive testimony regarding these updates to the Residents' and Fellows' Bill of Rights. We appreciate the thoughtful report put forward by the AMA-RFS Committee on Medical Education and commend them for what we felt were very important changes and in keeping with the benefits and protections that should be afforded to all trainees. Your Reference Committee offered an editorial change to clarify one of the statements and recommends that Report C be adopted as amended and the remainder of the report be filed.

(6) RESOLUTION 2 – DISAGGREGATION OF DEMOGRAPHIC DATA FOR INDIVIDUALS OF MIDDLE EASTERN AND NORTH AFRICAN (MENA) DESCENT

RECOMMENDATION A:

The Second and Third Resolve of Resolution 2 be amended by deletion.

~~RESOLVED, That our AMA advocate for the use of "Middle Eastern/North African (MENA)" as a separate demographic identifier in all medical records; and be it further~~

~~RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of "Middle Eastern/North African (MENA)" as a demographic identifying category in the U.S. Census and for all federally-funded research using racial/ethnic categories.~~

RECOMMENDATION B:

Resolution 2 be amended by addition of a new Second Resolve to read as follows:

RESOLVED, That our AMA advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to

medical records, government data collection and research, and within medical education.

RECOMMENDATION C:

Resolution 2 be adopted as amended.

RFS ACTION: Resolution 2 adopted as amended.

RESOLVED, That our AMA add “Middle Eastern/North African (MENA)” as a separate racial category on all AMA demographics forms; and be it further

RESOLVED, That our AMA advocate for the use of “Middle Eastern/North African (MENA)” as a separate demographic identifier in all medical records; and be it further

RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of “Middle Eastern/North African (MENA)” as a demographic identifying category in the U.S. Census and for all federally-funded research using racial/ethnic categories.

Your Reference Committee heard largely supportive testimony for this resolution and determined it to be a novel policy. In effort to be all-encompassing and including MENA as a separate race category in all uses of demographic data, combined with the redundancies noted between the second and third resolve clauses and the potential for other sites of demographic data collection being unintentionally omitted by the list format, we recommend a new resolve clause be adopted in its place. In this new clause, all the content of the second and third resolve clauses was included, as well as the author-submitted amendment for the use of the term “race category”. Therefore, your Reference Committee recommends Resolution 2 be adopted as amended.

(7) RESOLUTION 6 – PRESERVING APPROPRIATE PHYSICIAN SUPERVISION OF MIDLEVEL PROVIDERS AND ENSURING PATIENT AWARENESS OF THE QUALIFICATIONS OF PHYSICIANS VS. MIDLEVEL PROVIDERS

RECOMMENDATION A:

The First Resolve of Resolution 6 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA reaffirm policies H-160.947 and H-160.950 ~~advocate that midlevel providers practicing independently without physician supervision be required to obtain informed consent from patients acknowledging and understanding that they are not being treated by a physician~~; and be it further

RECOMMENDATION B:

The Third Resolve of Resolution 6 be amended by deletion.

~~**RESOLVED, That our AMA advocate for the appropriate supervision of midlevel providers by physicians as opposed to “collaboration,” which falsely equates non-physician training to that of physicians; and be it further**~~

RECOMMENDATION C:

Resolution 6 be adopted as amended.

RFS ACTION: Resolution 6 adopted as amended.

RESOLVED, That our AMA advocate that midlevel providers practicing independently without physician supervision be required to obtain informed consent from patients acknowledging and understanding that they are not being treated by a physician; and be it further

RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to “supervise” midlevel providers; and be it further

RESOLVED, That our AMA advocate for the appropriate supervision of midlevel providers by physicians as opposed to “collaboration,” which falsely equates non-physician training to that of physicians; and be it further

RESOLVED, That our AMA oppose mandatory physician supervision of midlevel providers as a condition for physician employment and in physician employment contracts, especially when physicians are not provided adequate resources and time for this responsibility; and be it further

RESOLVED, That our AMA advocate for the right of physicians to deny “supervision” to any midlevel provider whom they deem a danger to patient safety and the ability to report unsafe care provided by mid-levels to the appropriate regulatory board with whistleblower protections for physician employment.

Your Reference Committee heard mixed, but largely supportive testimony for this resolution including from the authors and the AMA-RFS Committee on Legislation and Advocacy. Testimony noted the lack of evidence of benefit of any informed consent process for midlevel providers practicing independently and the potential increased burden to patients. Your Reference Committee would also like to highlight existing AMA policies H-160.947(8) and H-160.950(9) that directly address how midlevel providers should inform patients of their responsibility and level of training. Therefore, we recommend reaffirming these policies which cover the asks in the first resolve clause. Testimony also noted the lack of functional change to existing AMA policy and practice in the third resolve clause by the "Stop the Scope Creep" campaign, and thus we recommended removal of this resolve clause. The remaining resolve clauses received general support without any explicit testimony and are therefore

recommended for adoption as written. Therefore, your Reference Committee recommends Resolution 6 be adopted as amended.

(8) RESOLUTION 7 – PHYSICIAN OPPOSITION TO THE COORDINATED EFFORT BY CORPORATIONS AND MIDLEVEL PROVIDERS TO UNDERMINE THE PHYSICIAN-PATIENT RELATIONSHIP AND SAFE QUALITY CARE

RECOMMENDATION A:

Resolution 7 be amended by addition and deletion to read as follows:

~~RESOLVED, That our AMA acknowledge that the corporate practice of medicine has led to diminished quality of patient care, erosion of the physician-patient relationship, erosion of physician-driven care, physician burnout, and created a conflict of interest between profit and training the next generation of physicians needed for our nations physician shortage; and be it further~~

RESOLVED, That our AMA study the impact that individual physician scope of practice advocacy has had on physician employment and contract terminations ~~work with relevant stakeholders to support and provide legal resources to physicians who are terminated from employment for speaking out about scope of practice issues~~; and be it further

RESOLVED, That our AMA study the views of patients on physician and non-physician care to identify best practices in educating the general population on the value of physician-led care ~~lead a national campaign to educate patients on the value of physician-led care and about the Dunning-Kruger effect in order to combat the false campaigns by midlevel providers/non-physicians~~; and be it further

RESOLVED, That our AMA study the utility of ~~work with relevant stakeholders to create~~ a physician-reported database to track and report institutions that replace physicians with midlevel providers ~~and develop a platform~~ in order to aid patients in seeking physician-led medical care as opposed to care by midlevel providers practicing without physician supervision.

RECOMMENDATION B:

Resolution 7 be adopted as amended.

RFS ACTION: Resolution 7 __adopted as amended__.

RESOLVED, That our AMA acknowledge that the corporate practice of medicine has led to diminished quality of patient care, erosion of the physician-patient relationship, erosion of physician-driven care, physician burnout, and created a conflict of interest between profit and training the next generation of physicians needed for our nations physician shortage; and be it further

RESOLVED, That our AMA work with relevant stakeholders to support and provide legal resources to physicians who are terminated from employment for speaking out about scope of practice issues; and be it further

RESOLVED, That our AMA lead a national campaign to educate patients on the value of physician-led care and about the Dunning-Kruger effect in order to combat the false campaigns by midlevel providers/non-physicians; and be it further

RESOLVED, That our AMA work with relevant stakeholders to create a physician-reported database to track and report institutions that replace physicians with midlevel providers and develop a platform to aid patients in seeking physician-led medical care as opposed to care by midlevel providers practicing without physician supervision.

Your Reference Committee heard mixed testimony on this resolution. Testimony on the first resolve clause noted its similarities to AMA policy H-215.981, and though the authors believed it went beyond the original language, we felt as though this still functionally similar to the past policy, as well as the detailed issue brief published in 2019 on the subject (https://www.ama-assn.org/system/files/2019-12/issue-brief-corporate-investors.pdf) and would thus result in reaffirmation in the AMA House of Delegates.

The subsequent resolve clauses ask for several items that we are recommending for further study based on testimony. The second resolve clause asks for legal resources for physicians facing termination; however, there is a paucity of data on the extent of this problem, nor are there examples of legal solutions. Testimony on the third resolve clause generally expressed support for the spirit of the resolve clause and the AMA-RFS Committee on Legislation and Advocacy recommended that ongoing AMA campaigns such as “Stop the Scope Creep” and “Ask for a Physician” address this request. The lack of evidence supporting such a novel, costly national campaign is notable, without even a pilot study, thus, studying the issue first may be a more cost-effective approach. Similar sentiments were expressed regarding the fourth resolve clause and therefore we recommend amending this clause for further study. Your Reference Committee would like to point out that the AMA policy compendium contains numerous policies on scope of practice that are detailed, firm, evidence-based, and respectful, and any new policy that we put forward should meet parallel standards. These policies include D-35.985, H-160.949, H-35.988, H-405.969, H-330.992, D-35.982, H-35.970, H-35.989, H-35.973, H-35.974, H-360.987, H-35.992, H-35.993, H-160.929, and D-35.988. Therefore, your Reference Committee recommends that Resolution 7 be adopted as amended.

(9) RESOLUTION 9 – THE IMPACT OF PRIVATE EQUITY ON MEDICAL TRAINING

RECOMMENDATION A:

The First Resolve of Resolution 9 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with relevant stakeholders including specialty societies and the ACGME to study the level of financial involvement and influence ~~on medical practice and education of~~ private equity firms have in graduate medical education training programs and report back at I-21 with concurrent publication of their findings in a peer-reviewed journal; and be it further

RECOMMENDATION B:

Resolution 9 be adopted as amended.

RFS ACTION: Resolution 9 adopted as amended.

RESOLVED, That our AMA work with relevant stakeholders including specialty societies and the ACGME to study the level of financial involvement and influence on medical practice and education of private equity firms in graduate medical education training programs and report back at I-21 with concurrent publication of their findings in a peer-reviewed journal; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the June 2021 Special Meeting of the HOD.

Your Reference Committee heard mostly supportive testimony for this resolution, with some concerns regarding urgency for immediate forwarding to the June 2021 Special Meeting of the HOD and reporting back for I-21. Additionally, your Reference Committee appreciated comments from AMA staff, which recommended amendment by removing the word "medical practice" from the first resolve clause, as to focus the resolution solely on the impact of private equity on medical education, which will avoid overlap with an ongoing AMA Council on Medical Service study focused on private equity in medical practice.

Regarding the elements of timing, your Reference Committee had a robust discussion which echoed comments from the authors on the Virtual Reference Committee regarding the urgency of this issue and how it is presently affecting graduating residents in fields that are becoming oversaturated, such as emergency medicine. Finally, your Reference Committee heard additional concerns from AMA staff regarding the call for publication of the study results in a peer-reviewed journal; however, your Reference Committee agrees with the author's commentary that the results of these findings deserve a more widespread audience beyond the AMA policy compendium, and as such, calls for publication are in line with the goals of

our RFS. Therefore, your Reference Committee recommends Resolution 9 be adopted as amended.

(10) RESOLUTION 10 – REDUCING OVERALL FEES AND MAKING COSTS FOR LICENSING, EXAM FEES, APPLICATION FEES, ETC. EQUITABLE FOR IMGS

RECOMMENDATION A:

The First Resolve of Resolution 10 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA work with ~~the ACGME, NBME, ECFMG, FSMB, and other~~ all relevant stakeholders to reduce application, exam, licensing fees and related financial burdens for IMGs to ensure cost equity with US MD and DO trainees.

RECOMMENDATION B:

Resolution 10 be amended by addition of a new Second Resolve to read as follows:

RESOLVED, that our AMA amend current policy H-255.966 "Abolish Discrimination in Licensure of IMGs" by addition to read as follows:

> **"2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements, and associated costs, for all physicians, whether U.S. medical school graduates or international medical graduates."**

RECOMMENDATION C:

Resolution 10 be adopted as amended.

> **RFS ACTION: Resolution 10 adopted as amended.**

RESOLVED, That our AMA work with the ACGME, NBME, ECFMG, FSMB, and other relevant stakeholders to reduce application, exam, licensing fees and related financial burdens for IMGs.

Your Reference Committee heard limited but unanimous testimony supporting this Resolution and suggested amendments. Testimony highlighted the negative impact of seemingly subtle financial incentives, for example, noting the favoring of trainees on J1 visas over those on H1B visas. Your Reference Committee made changes that reflect these friendly amendments. Therefore, your Reference Committee recommends Resolution 10 be adopted as amended.

(11) RESOLUTION 13 – COVID-19 VACCINATION ROLLOUT TO EMERGENCY DEPARTMENTS AND URGENT CARES

RECOMMENDATION A:

Resolution 13 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA acknowledge that our nation's COVID-19 vaccine rollout is not yet optimized, and we have a duty to vaccinate as many people in an effective manner; and be it further

RESOLVED, That our AMA work with other relevant organizations and stakeholders to lobby the current Administration for the distribution of COVID-19 vaccinations to our nation's emergency departments and urgent ~~cares~~ care facilities; and be it further

RESOLVED, That our AMA advocate for additional funding to be directed towards increasing COVID-19 vaccine ambassador programs in emergency departments and urgent care facilities; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the June 2021 Special Meeting of the HOD.

RECOMMENDATION B:

**The title of Resolution 13 be changed to read as follows:
COVID-19 VACCINATION ROLLOUT TO EMERGENCY DEPARTMENTS AND URGENT CARE FACILITIES**

RECOMMENDATION C:

Resolution 13 be adopted as amended with a change in title.

RFS ACTION: Resolution 13 adopted as amended with a change in title.

RESOLVED, That our AMA acknowledge that our nation's vaccine rollout is not yet optimized, and we have a duty to vaccinate as many people in an effective manner; and be it further

RESOLVED, That our AMA lobby the current Administration for the distribution of vaccinations to our nation's emergency departments and urgent cares; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the June 2021 Special Meeting of the HOD.

Your Reference Committee heard testimony largely in support of this resolution with proposals for amendments. Overall, your Reference Committee recognizes the importance of the COVID-19 vaccination campaign and the unique role that emergency departments and urgent care facilities play in treating the underserved which have been disproportionately affected by the COVID-19 pandemic. Testimony recommended the addition of "COVID-19" before the words "vaccine" and "vaccinations" to maintain focus on this specific vaccination campaign. Additionally, your Reference Committee felt it important to include the language of "other relevant organizations and stakeholders" for the AMA to partner with to bolster its lobbying efforts to the current Administration in combatting COVID-19.

Further, the AMA-RFS Committee on Legislation and Advocacy proposed a friendly amendment to add a resolve clause focusing on the funding and allocation of resources devoted to education of the COVID-19 vaccination campaign in emergency departments, which we felt germane to the author's original intent of this resolution. Finally, to avoid syntactical confusion, your Reference Committee recommends change the term "urgent cares" to "urgent care facilities" in both the resolve clauses and title of the original resolution. We appreciate the timely nature of this topic and support immediate forwarding to the AMA House of Delegates. Therefore, your Reference Committee recommends Resolution 13 be adopted as amended.

(12) RESOLUTION 15 – FULFILLING MEDICINE'S SOCIAL CONTRACT WITH HUMANITY IN THE FACE OF THE CLIMATE HEALTH CRISIS

RECOMMENDATION A:

Resolution 15 be amended by addition and deletion to read as follows:

~~**RESOLVED, that our AMA advocate at all levels of government for equitable policies to transition rapidly away from the use of coal, oil and natural gas to clean, safe, and renewable energy and energy efficiency; and be it further**~~

RESOLVED, that our AMA reaffirm policy H-135.949 "Support of Clean Air and Reduction in Power Plant Emissions"; and be it further

RESOLVED, that our AMA establish a climate crisis campaign that will distribute evidence-based information on the relationship between climate change and human health, determine high-yield advocacy and leadership opportunities for physicians, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon ~~create an appropriate climate health crisis-focused longitudinal body or center for the purpose of determining the highest-yield advocacy leadership opportunities for our AMA in this public health crisis and for coordinating, strengthening and centralizing efforts toward advocating for an equitable and inclusive transition to a climate-neutral~~ society by 2050.

RECOMMENDATION B:

Resolution 15 be adopted as amended.

RFS ACTION: Resolution 15 adopted as amended.

RESOLVED, that our AMA advocate at all levels of government for equitable policies to transition rapidly away from the use of coal, oil and natural gas to clean, safe, and renewable energy and energy efficiency; and be it further

RESOLVED, that our AMA create an appropriate climate health crisis-focused longitudinal body or center for the purpose of determining the highest-yield advocacy leadership opportunities for our AMA in this public health crisis and for coordinating, strengthening and centralizing efforts toward advocating for an equitable and inclusive transition to a climate-neutral society by 2050.

Your Reference Committee heard mixed testimony on this resolution. The authors offered a friendly amendment to clarify language to the second resolve clause and add a third resolve clause with an immediate forward to the HOD. Overall, there was significant testimony opposing the first and proposed third resolve clauses, due to the redundancy of the first resolve clause as repetitive of H-135.949 Support of Clean Air and Reduction in Power Plant Emissions, and due to the presumed difficulty in passage of such a complex, expensive resolution in a virtual format.

There was testimony in support of the spirit of the amended second resolve clause, but the language remained vague. Your Reference Committee took all testimony under consideration and elected to recommend reaffirmation of the existing policy H-135.949 in lieu of the first resolve clause and offered amended language to try and capture the intention of the authors' request for a Center or longitudinal body in the second resolve clause, considering this to be a campaign similar in design to the AMA's "Scope of Practice Partnership" and "Save GME" campaigns. Your Reference Committee did not hear compelling testimony supporting immediate forwarding and elected to exclude this proffered amendment in its final recommended language. Therefore, your Reference Committee recommends Resolution 15 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(13) RESOLUTION 4 – OPPOSITION TO MID-LEVEL PROVIDER BIAS AGAINST PHYSICIANS AND PHYSICIAN-LED CARE
RESOLUTION 5 – NON-PHYSICIAN CONTINUED EDUCATION, SPECIALTY AND SUBSPECIALTY TRAINING

RECOMMENDATION A:

Alternate Resolution 4 be adopted in lieu of Resolutions 4 and 5.

THE IMPACT OF MIDLEVEL PROVIDERS ON MEDICAL EDUCATION

RESOLVED, That our AMA study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within undergraduate medical education and graduate medical education, interprofessional learning and team building work and publish these findings in peer-reviewed journals ~~methods to regulate and ensure non-physician post-graduate education is rigorous and adequate to maintain the ability to practice within the intended field of practice with physician oversight~~; and be it further

RESOLVED, That our AMA work with the LCME and ACGME to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated and standardized education they receive; and be it further

RESOLVED, That our AMA study the harms and benefits of establishing mandatory postgraduate clinical training for Nurse Practitioners and Physician Assistants prior to working within a specialty or subspecialty field; and be it further

RESOLVED, That our AMA study the harms and benefits of establishing national requirements for structured and regulated continued education for Nurse Practitioners and Physician Assistants in order to maintain licensure to practice.

RECOMMENDATION B:

Alternate Resolution 4 be adopted.

RFS ACTION: Alternate Resolution 4 adopted as amended.

Resolution 4
RESOLVED, That our AMA work with the Liaison Committee on Medical Education (LCME) and Accreditation Council for Graduate Medical Education (ACGME) to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated, and standardized education they receive; and be it further

RESOLVED, That our AMA work with the LCME and ACGME to recognize and eliminate any bias against physician-led healthcare in all physician training, inter-professional learning and team building work; and be it further

RESOLVED, That our AMA oppose the false narrative that physicians that seek to protect patients by preserving physician-led healthcare are being "disrespectful" or "not team players" and that the only way to "respect" mid-level providers is to equate their training to that of physicians and support their push for independent practice.

Resolution 5
RESOLVED, That our AMA study methods to regulate and ensure non-physician post-graduate training and continued education requirements are rigorous and adequate for the intended field of practice with physician oversight and to maintain the ability to continue to practice; 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) work with relevant stakeholders and regulatory agencies to support the requirement of mandatory postgraduate clinical training for Nurse Practitioners and Physician Assistants prior to working within a specialty or subspecialty field.
>
> (8) work with relevant stakeholders and regulatory agencies to support the requirement of structured and regulated continued education for Nurse Practitioners and Physician Assistants in order to continue to maintain certification to practice; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the June 2021 Special Meeting of the HOD.

Your Reference Committee heard extensive, mixed testimony on both Resolutions 4 and 5, with similar sentiments expressed on each from several individuals, our RFS Committee on Legislation and Advocacy, and the Massachusetts delegation. The two resolutions have been combined here for expediency in the House of Delegates and because of their overlapping focus on the impact of midlevel providers on medical education. Supportive testimony agreed

with the spirit of the resolve clauses while also noting the lack of evidence on these issues and the potential for unintended consequences from implementing solutions without clear evidence for benefit or pilot study. Unfortunately, the only source utilized in these two resolutions is a book, and we are unable to verify whether the Whereas clauses are supported by anecdotes, case reports, clinical trials, or other forms of research. No results from peer-reviewed literature are directly quoted so the existence and extent of the problems that are outlined in these resolutions are unknown and therefore should be studied before solutions are implemented.

Your Reference Committee proposes Alternate Resolution 4 that consolidates these two items. The first through third resolve clauses from Resolution 4 are replaced with the first resolve clause in Alternate Resolution 4, which asks our AMA to study the impact of bias against physician-led healthcare in undergraduate and graduate medical education. Then, the first and second resolve clauses from Resolution 5 are replaced with the second through fourth resolve clauses in Alternate Resolution 4, which asks our AMA to study the ways in which non-physician post-graduate training and continued medical education could be implemented. Lastly, the third resolve clause from Resolution 5 was removed because this item does not meet any criteria to justify immediate forwarding as evidenced by several individuals' testimonies. Therefore, your Reference Committee recommends Alternate Resolution 4 be adopted in lieu of Resolutions 4 and 5.

(14) RESOLUTION 12 – ADDRESSING GAPS IN PATIENT AND PROVIDER KNOWLEDGE TO INCREASE HPV VACCINE UPTAKE AND PREVENT HPV-ASSOCIATED OROPHARYNGEAL CANCER

RECOMMENDATION A:

Alternate Resolution 12 be adopted in lieu of Resolution 12.

ADDRESSING GAPS IN PATIENT AND PROVIDER KNOWLEDGE TO INCREASE HPV VACCINE UPTAKE AND PREVENT HPV-ASSOCIATED OROPHARYNGEAL CANCER

RESOLVED, that our AMA amend current policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by addition and deletion to read as follows:

1. **Our AMA (a) urges physicians to educate themselves and their patients about all HPV-mediated ~~and associated~~ diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.**

2. **Our AMA will intensify efforts to improve awareness and understanding about all HPV-mediated ~~and~~**

~~associated~~ diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.

3. **Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.**

4. **Our AMA supports efforts (a) to enhance awareness in the general public regarding the association between HPV infection and oropharyngeal squamous cell carcinoma, and (b) to further develop oropharyngeal squamous cell carcinoma screening tools.**

RESOLVED, that our AMA amend current policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by title change to "HPV Vaccine and ~~Cervical~~ HPV-mediated Cancer Prevention Worldwide"; and be it further

RESOLVED, that our AMA reaffirm policies D-170.995 "Human Papillomavirus (HPV) Inclusion in our School Education Curricula" and D-440.955 "Insurance Coverage for HPV Vaccine".

RECOMMENDATION B:

Alternate Resolution 12 be adopted.

RFS ACTION: Alternate Resolution 12 adopted.

RESOLVED, That our AMA-RFS support efforts to increase rates of HPV vaccination among males and females; and be it further

RESOLVED, That our AMA-RFS support efforts to increase physician awareness of HPV-associated OPSCC and to develop comprehensive training in HPV vaccine counseling relevant to all stakeholders; and be it further

RESOLVED, That our AMA support efforts to enhance awareness in the general public regarding the association between HPV infection and OPSCC; and be it further

RESOLVED, That our AMA support increased efforts for the development of OPSCC screening tools.

Your Reference Committee heard unanimous testimony supporting the spirit of this resolution, but mixed testimony regarding tactics to achieve its intended goals. Several individuals and members of the RFS Committee on Legislation and Advocacy pointed out the similarities of the first and second resolve clauses with existing AMA policy H-440.872 “HPV Vaccine and Cervical Cancer Prevention Worldwide” and suggested amending the existing resolution. To minimize redundancy and build on existing policy, your Reference Committee wrote an alternate resolution using the framework of H-440.872 and substituting in language from Resolution 12. Furthermore, your Reference Committee clarified the need for broader awareness of "all HPV-mediated diseases" as recommended by testimony. Finally, your Reference Committee recommended a title change to H-440.872 to reflect the aforementioned amendments and reaffirmation of other relevant HPV vaccine policies (D-170.995 “Human Papillomavirus (HPV) Inclusion in our School Education Curricula” and D-440.955 “Insurance Coverage for HPV Vaccine”) to re-emphasize the importance of AMA advocacy on these issues. Therefore, your Reference Committee recommends Alternate Resolution 12 be adopted in lieu of Resolution 12.

(15) RESOLUTION 14 – EXPANDING THE AMA’S STUDY ON THE ECONOMIC IMPACT OF COVID-19

RECOMMENDATION A:

Alternate Resolution 14 be adopted in lieu of Resolution 14.

EXPANDING THE AMA’S STUDY ON THE ECONOMIC IMPACT OF COVID-19

RESOLVED, That our AMA work with relevant organizations and stakeholders to study the economic impact and long-term recovery of the COVID-19 pandemic on healthcare institutions in order to identify and better understand which groups of physicians, patients and organizations may have been disproportionately affected by the financial burdens of the COVID-19 pandemic; and be it further

RESOLVED, that our AMA work with relevant organizations and stakeholders to study the overall economic impact of office closures, cancellations of elective surgeries and interruptions in patient care, as well as the economic impact of utilizing telemedicine for an increasing percentage of patient care.

RECOMMENDATION B:

Alternate Resolution 14 be adopted.

RFS ACTION: Alternate Resolution 14 adopted.

1 RESOLVED, That our AMA study the economic impact of the COVID-19 pandemic in order
2 to identify and better understand groups of physicians and patients that may have been
3 disproportionately affected by the financial burdens of the COVID-19 pandemic; and be it
4 further
5
6 RESOLVED, that our AMA work with relevant organizations and stakeholders to study the
7 long-term economic recovery of healthcare institutions including how the financial solvency
8 and existential security of public, private, and other healthcare institutions across the country
9 have been affected by lost revenues and unanticipated costs incurred during the COVID-19
10 pandemic.
11
12 Your Reference Committee heard limited, but overall supportive testimony for the proposals
13 of this resolution. We recognize the importance of studying the economic impact of the
14 COVID-19 pandemic on healthcare institutions and discrepancies in the financial burden
15 experienced by different organizations across the nation. However, the proposals in the first
16 and second resolve clauses were unclear in terms of their timelines on when data should be
17 examined, and we as a Reference Committee were unsure if one or multiple studies were
18 being proposed by the authors. We also felt that the two resolve clauses were redundant and
19 recommend an alternate resolved clause lieu of the original two resolve clauses to adequately
20 cover the questions asked in the original resolution. We also commend the AMA-RFS
21 Committee on Legislation and Advocacy for their proposal of a separate resolve clause
22 specifically focusing on the impact of office closures, cancelled surgeries and utilization of
23 telemedicine and as such, included it in our final recommendation. Therefore, your Reference
24 Committee recommends Alternate Resolution 14 be adopted in lieu of Resolution 14.

RECOMMENDED FOR REFERRAL

(16) RESOLUTION 11 – INCREASING MUSCULOSKELETAL EDUCATION IN PRIMARY CARE SPECIALTIES AND MEDICAL SCHOOL EDUCATION THROUGH INCLUSION OF OSTEOPATHIC MANUAL THERAPY EDUCATION

RECOMMENDATION:

Resolution 11 be referred.

RFS ACTION: Resolution 11 referred.

RESOLVED, That our American Medical Association advocate to the Liaison Committee on Medical Education and other relevant stakeholders for the incorporation of Osteopathic Manual Therapy into the education curriculum of allopathic schools in the United States; and be it further

RESOLVED, That our AMA advocate to the Accreditation Council for Graduate Medical Education and other relevant stakeholders for the incorporation of Osteopathic Manual Therapy into the education curriculum of all primary care residency training programs in the United States; and be it further

RESOLVED, That our AMA continue to support equal treatment of osteopathic students, trainees and physicians in the residency application cycle and workplace through continued education on the training of Osteopathic physicians.

Your Reference Committee heard mixed testimony, largely opposing the passage of this resolution due to concerns regarding curricular mandates and some of the practices used in the Osteopathic Manual Therapy curriculum. However, the authors' testimony and proposed amended language focusing on applications in the treatment of musculoskeletal disorders suggest that a study on areas to improve understanding and usage of Osteopathic Manual Therapy could be useful to guide future policy recommendations. Therefore, your Reference Committee recommends that Resolution 11 be referred for study.

RECOMMENDED FOR NOT ADOPTION

(17) RESOLUTION 3 – TITLE CHANGE TO HOD POLICY D-383.996 "IMPACT OF THE NLRB RULING IN THE BOSTON MEDICAL CENTER CASE"

RECOMMENDATION:

Resolution 3 not be adopted.

RFS ACTION: Resolution 3 not adopted.

RESOLVED, That AMA Policy D-383.996 be amended by title change to read as follows: ~~"Impact of the NLRB Ruling in the Boston Medical Center Case"~~ "AMA Resources, Advocacy, and Leadership Efforts to Secure Labor Protections for Physicians in Training."

Your Reference Committee appreciates the authors in alerting staff and your Reference Committee of this very necessary and important title change, to inform of the content of this policy and to avoid future sunsetting without our awareness. After discussion with the House of Delegates office, it was determined that this title change can be done through a Speaker's Policy Reconciliation Report at I-21, which we feel is appropriate and avoids a potential debate that may result in substantial changes to the policy that do not appear to be the intention of the authors. Therefore, your Reference Committee recommends Resolution 3 not be adopted.

(18) RESOLUTION 8 – REVISING THE CMS DEFINITION OF "PHYSICIAN"

RECOMMENDATION:

Resolution 8 not be adopted.

RFS ACTION: Resolution 8 not adopted.

RESOLVED, That our AMA advocate to restrict the CMS definition of "Physician" to only Allopathic (MD) and Osteopathic (DO) physicians and the international equivalents of these degrees.

Your Reference Committee heard mixed testimony on this resolution, with an overall consensus that existing AMA policy H-330.992 provides broad enough language to accomplish the ask in this resolution. Your Reference Committee entertained the idea of substituting the word "advocacy" for "support" in AMA policy H-330.992, however, ultimately felt that this change would be semantic and would still result in reaffirmation in the AMA House of Delegates. As an alternative, we recommend the authors submit an action request to the AMA-RFS GC to work with the AMA Board of Trustees on stronger advocacy to limit the definition of the term physician under the Medicare program. Therefore, your Reference Committee recommends that Resolution 8 not be adopted.

1 (19) RESOLUTION 17 – RESIDENCY PROGRAM SOCIAL MEDIA
2 PRESENCE TO INCREASE INFORMATION AVAILABLE TO
3 APPLICANTS
4
5 **RECOMMENDATION:**
6
7 **Resolution 17 not be adopted.**
8
9 **RFS ACTION: Resolution 17 not adopted.**
10
11 RESOLVED, That our AMA study existing communication practices during the residency
12 application process; and be it further
13
14 RESOLVED, That our AMA develop best practices for the use of social media by residency
15 programs; and be it further
16
17 RESOLVED, That our AMA support residency programs' social media presence as a means
18 to share updated information with applicants.
19
20 Your Reference Committee heard limited testimony on this resolution without any clear
21 support. Testimony indicated that social media management for residency and fellowship
22 programs was beyond the scope of the AMA. While we would hope that all programs have a
23 strong social media presence to showcase their outstanding trainees, faculty, and facilities,
24 there is simply insufficient manpower to achieve this in some cases. As a result, our AMA
25 supporting and guiding all programs' social media presence would not be the most optimal
26 use of resources for the organization. Instead, specialty societies may be the best resources
27 for providing social media tips, especially given that the recruiting process is so varied among
28 specialties, and some specialties have already started trending in this direction. Therefore,
29 your Reference Committee recommends Resolution 17 not be adopted.

Amar Kelkar, MD, Chair	David Savage, MD, PhD
Karen Dionesotes, MD, MPH	Jerome Jeevarajan, MD
Hunter Pattison, MD	Charles Lopresto, DO