

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1  
(A-21)

Introduced by: Gunjan Malhotra, M.D., Benjamin Meyer, M.D.

Subject: Gonad Shields: Regulatory and Legislation Advocacy to Oppose  
Routine Use

Referred to: Reference Committee

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- 1 Whereas, Led by the Society of Pediatric Radiology (SPR), the Image Gently Alliance was  
2 formed in late 2006 with the goal of “changing practice by raising awareness of the opportunities  
3 to lower radiation dose in the imaging of children” (1); and  
4
- 5 Whereas, The SPR recruited other organizations/members of the imaging team into the alliance  
6 in 2007 including the American College of Radiology (ACR), American Association of Physicists  
7 in Medicine (AAPM), and American Society of Radiologic Technologists (ASRT) (1); and  
8
- 9 Whereas, The practice of shielding reproductive organs and in utero fetuses began in the 1950s  
10 given concerns about the long-term effects of radiation and the potential for passing on genetic  
11 mutations through genetic inheritance (2,3); and  
12
- 13 Whereas, In response to these concerns, state and federal laws and regulations have been  
14 created requiring the use of gonad shields in medical imaging studies (4,5); and  
15
- 16 Whereas, Through technological advances, medical physicists estimate the dose from routine  
17 diagnostic imaging to reproductive organs has been reduced by 95% without compromising  
18 diagnostic quality (2,3); and  
19
- 20 Whereas, Technological advances and optimization have resulted in marginal hereditary risk  
21 reduction from gonad shielding ranging from  $1 \times 10^{-6}$  in women and  $5 \times 10^{-6}$  in men (6); and  
22
- 23 Whereas, Research on radiation dosing has shown that routine diagnostic imaging does not  
24 produce harmful levels of radiation to patients and fetuses (2,3); and  
25
- 26 Whereas, Modern mechanisms to optimize imaging parameters such as automatic exposure  
27 control (AEC) are negatively affected by shielding (7); and  
28
- 29 Whereas, The gonad shield results in decreased activity on the detector, triggering AEC to  
30 increase radiation output, which results in increased exposure and patient dose along with the  
31 degradation of image quality (7); and  
32
- 33 Whereas, The gonad shield produces artifacts and can obscure relevant anatomy and  
34 diagnostic information (7); and  
35
- 36 Whereas, Non-diagnostic or obscured images may need to be repeated increasing patient dose  
37 when shields are used (7); and  
38
- 39 Whereas, The gonad surface shield is ineffective at reducing internal scatter (7); and

1 Whereas, Studies have shown that gonad shields are incorrectly placed for females in 91% of  
2 radiographs and for males in 66% of radiographs, rendering them ineffective (8,9); and  
3

4 Whereas, On January 12th, 2021 the National Council on Radiation Protection and  
5 Measurements (NCRP) issued a statement that the risks of utilizing gonad shields far outweigh  
6 the negligible benefits to reproductive organs and therefore they should not be routinely used  
7 (10); and  
8

9 Whereas, Similar statements opposing routine or mandatory use of gonadal shields were  
10 released by the ACR and the AAPM in 2019 and by the ASRT in 2021 (11,12); therefore be it  
11

12 RESOLVED, That our AMA oppose mandatory use of gonad shields in medical imaging  
13 considering the risks far outweigh the benefits; and be it further  
14

15 RESOLVED, That our AMA advocate that the FDA amend the code of federal regulations to  
16 oppose the routine use of gonad shields in medical imaging; and be it further  
17

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

Fiscal Note:

#### References

1. <https://www.imagegently.org/About-Us/Campaign-Overview>
2. <https://www.aapublications.org/news/2020/03/31/xrayshields040120>
3. <https://www.radiologyinfo.org/en/info.cfm?pg=safety-patient-shielding>
4. [https://www.ecfr.gov/cgi-bin/text-idx?SID=c6fd98dfc8955d41420798f3e5357c66&mc=true&node=se21.8.1000\\_150&rgn=div8](https://www.ecfr.gov/cgi-bin/text-idx?SID=c6fd98dfc8955d41420798f3e5357c66&mc=true&node=se21.8.1000_150&rgn=div8)
5. <https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?fr=1000.50>
6. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7005227/>
7. <https://www.aapm.org/org/policies/details.asp?id=468&type=PP&current=true>
8. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3292647/>
9. <https://pubmed.ncbi.nlm.nih.gov/28437549/>
10. <https://ncrponline.org/wp-content/themes/ncrp/PDFs/Statement13.pdf>
11. <https://www.acr.org/Advocacy-and-Economics/Advocacy-News/Advocacy-News-Issues/In-the-June-8-2019-Issue/ACR-Endorses-AAPM-Position-on-Patient-Gonadal-and-Fetal-Shielding>
12. <https://www.asrt.org/main/news-publications/news/article/2021/01/12/asrt-statement-on-fetal-and-gonadal-shielding>

**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 2  
(A-21)

Introduced by: Deena Kishawi, MD

Subject: Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent

Referred to: Reference Committee

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1 Whereas, The American Association of Physical Anthropologists believes that “race does not  
2 have its roots in biological reality, but...has become a social reality that structures societies and  
3 how we experience the world. In this regard, race is real, as is racism, and both have real  
4 biological consequences ”;<sup>1</sup> and  
5

6 Whereas, People of Middle Eastern and North African (MENA) descent are not recognized as  
7 belonging to a unique, independent racial category in the U.S. Census data, and instead they  
8 are aggregated under “White”;<sup>2</sup> and  
9

10 Whereas, MENA designation is not included in the National Institute of Health’s racial and ethnic  
11 categories, and thus is not required to be considered in any federally-funded research;<sup>3</sup> and  
12

13 Whereas, MENA is not included as a race category nor an ethnicity category routinely collected  
14 in survey and demographic data in the U.S.;<sup>4,5</sup> and  
15

16 Whereas, There are discrepancies in the total population of MENA populations across the US  
17 due to inaccurate identification and aggregation;<sup>2,5</sup> and  
18

19 Whereas, There is limited research about the healthcare of populations from the MENA region  
20 in U.S. epidemiological and public health literature and existing literature is focused on ethnic  
21 enclaves which may not be reflective of the community as a whole;<sup>4,6</sup> and  
22

23 Whereas, Americans of MENA descent disproportionately constitute immigrants from the past  
24 two decades, share a set of cultural norms, and face recent marginalization and discrimination  
25 towards this population;<sup>4,5,7</sup> and  
26

27 Whereas, MENA populations have different risk factors and social determinants including high  
28 rates of immigration and individuals seeking asylum;<sup>6,8,9</sup> and  
29

30 Whereas, To the knowledge of the authors there has never been a prospective study examining  
31 the health needs of MENA communities in the U.S.;<sup>4</sup> and  
32

33 Whereas, Genetic disorders and familial inherited cancers occur at a higher frequency in some  
34 MENA populations due to higher rates of consanguineous marriages, most commonly with first  
35 cousins;<sup>10</sup> and  
36

37 Whereas, Discrimination against MENA populations in the U.S. increased dramatically after  
38 September 11th, 2001, including increased harassment, discrimination, violence, and targeted  
39 hate crimes that have resulted in worsening health outcomes in this population;<sup>6,11,12</sup> and

1 Whereas, MENA populations in the US suffer from a high rate of serious psychosocial distress  
2 compared to the general population which may be in part due to their immigrant status;<sup>13</sup> and  
3

4 Whereas, Classifying MENA populations as “White” has led to their “cultural invisibility” and  
5 perpetuates a cycle of undocumented health disparities<sup>5</sup> that greatly affects funding for health-  
6 related research, targeting of effective and personalized healthcare, and prevents patient-  
7 centered care and engagement;<sup>4,5,6,10,14</sup> and  
8

9 Whereas, Including a race identifier for MENA populations on all medical records will increase  
10 the representation and visibility of the population, and increases the research and attention to  
11 the medical and public health needs of this community;<sup>4,5,6,15</sup> and  
12

13 Whereas, Despite analysis issued by the U.S. Census Bureau in 2017 that “it is optimal to use a  
14 dedicated ‘Middle Eastern or North African’ response category,” the Census Bureau declined to  
15 include a MENA identifier in the 2020 Census;<sup>16</sup> and  
16

17 Whereas, The U.S. Census is used to direct federal resources, funding, and research, making it  
18 vitally important in the promotion of medicine and public health, and the Census has  
19 acknowledged that its inaccuracies in collection of race and ethnicity data act as a barrier to the  
20 Census’ utility and accuracy;<sup>17</sup> and  
21

22 Whereas, Separating the demographic identifier as MENA will allow for the disaggregation of  
23 data, in order to appropriately target research, preventive measures, and healthcare  
24 engagement; therefore be it  
25

26 RESOLVED, That our AMA add “Middle Eastern/North African (MENA)” as a separate racial  
27 category on all AMA demographics forms; and be it further  
28

29 RESOLVED, That our AMA advocate for the use of “Middle Eastern/North African (MENA)” as a  
30 separate demographic identifier in all medical records; and be it further  
31

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

Fiscal Note:

**References:**

1. American Association of Physical Anthropologists. AAPA Statement on Race & Racism. <https://physanth.org/about/position-statements/aapa-statement-race-and-racism-2019/>. March 2019. Accessed March 11, 2021.
2. US Census 2020. <https://my2020census.gov/>. Accessed March 14, 2020.
3. NIH Policy and Guidelines on The Inclusion of Women and Minorities as Subjects in Clinical Research | [grants.nih.gov](https://grants.nih.gov). Accessed March 16, 2021. <https://grants.nih.gov/policy/inclusion/women-and-minorities/guidelines.htm>
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5. Abboud S, Chebli P, Rabelais E. The contested whiteness of Arab identity in the United States: Implications for health disparities research. *Am J of Pub Health*. 2019;109(11), 1580-1583.
6. Abuelezam NN, El-Sayed AM, Galea S. Arab American health in a racially charged US. *Am J of Preventive Med*. 2017;52(6), 810-812.
7. Rubin V, Ngo D, Ross A, Butler D, Balaram N. Counting a Diverse Nation: Disaggregating Data on Race and Ethnicity to Advance a Culture of Health. *Policylink*. Published online 2018.

- Accessed March 16, 2021.  
[https://www.policylink.org/sites/default/files/Counting\\_a\\_Diverse\\_Nation\\_08\\_15\\_18.pdf](https://www.policylink.org/sites/default/files/Counting_a_Diverse_Nation_08_15_18.pdf)
8. Abuelezam NN, El-Sayed AM, Galea S. Relevance of the “immigrant health paradox” for the health of Arab Americans in California. *Am J of Pub Health*. 2019;109(12), 1733-1738.
  9. Bertran EA, Pinelli NR, Sills SJ, Jaber LA. The Arab American experience with diabetes: Perceptions, myths and implications for culturally-specific interventions. *Primary Care Diabetes*. 2017;11(1), 13-19.
  10. AlHarthi FS, Qari A, Edress A, Abedalthagafi M. Familial/inherited cancer syndrome: a focus on the highly consanguineous Arab population. *NPJ Genomic Med*. 2020;5(1), 1-10.
  11. Awad GH, Kia-Keating M, Amer MM. A model of cumulative racial–ethnic trauma among Americans of Middle Eastern and North African (MENA) descent. *Am Psychologist*. 2019;74(1), 76.
  12. Phillips D, Lauterbach D. American Muslim Immigrant Mental Health: The Role of Racism and Mental Health Stigma. *Journal of Muslim Mental Health*. 2017;2(1). doi: <https://doi.org/10.3998/jmmh.10381607.0011.103>
  13. Alkaid Albqoor M, Chen JL, Weiss S, Waters C, Choi JW. Serious psychological distress: A national study of Middle Eastern immigrants. *J Psychiatr Ment Health Nurs*. 2020; doi:10.1111/jpm.12646
  14. Samhan H. Not Quite White: Race Classification and the Arab-American Experience. In Suleiman M. (Ed.), *Arabs in America: Building a New Future* 1999;209-226. Temple University Press. Retrieved March 11, 2020, from [www.jstor.org/stable/j.ctt14bswm3.17](http://www.jstor.org/stable/j.ctt14bswm3.17)
  15. Department of Commerce, et al v. New York, et al. Brief amicus curiae of the American Arab Institute. U.S. Supreme Court. April 2019. [https://www.supremecourt.gov/DocketPDF/18/18-966/94850/20190401151445423\\_AAI%20Amicus%20Brief.pdf](https://www.supremecourt.gov/DocketPDF/18/18-966/94850/20190401151445423_AAI%20Amicus%20Brief.pdf)
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  17. US Census Bureau. Research to improve data on race and ethnicity. March 2017. <https://www.census.gov/about/our-research/race-ethnicity.html>. Accessed March 15, 2021.

**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

**Disaggregation of Demographic Data Within Ethnic Groups H-350.954**

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. 2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

Citation: Res. 001, I-17Appended: Res. 403, A-19

**Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities H-315.963**

Our AMA encourages the Office of the National Coordinator for Health Information Technology (ONC) to expand their data collection requirements, such that electronic health record (EHR) vendors include options for disaggregated coding of race, ethnicity and preferred language.

Citation: Res. 03, I-19

### **Accuracy in Racial, Ethnic, Lingual and Religious Designations in Medical Records H-315.996**

Our AMA advocates precision without regulatory requirement or mandatory reporting of racial, ethnic, preferred language and religious designations in medical records, with information obtained from the patient, always respecting the personal privacy and communication preferences of the patient.

Citation: Res. 4, I-83Reaffirmed: CLRPD Rep. 1, I-93Reaffirmed: CSA Rep. 8, A-05Modified: CSAPH Rep. 1, A-15Modified: Res. 03, I-19

### **Racism as a Public Health Threat H-65.952**

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
5. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20

### **Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953**

1. Our AMA recognizes that race is a social construct and is distinct from ethnicity, genetic ancestry, or biology.
2. Our AMA supports ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice.
3. Our AMA encourages undergraduate medical education, graduate medical education, and continuing medical education programs to recognize the harmful effects of presenting race as biology in medical education and that they work to mitigate these effects through curriculum change that: (a) demonstrates how the category “race” can influence health outcomes; (b) that supports race as a social construct and not a biological determinant and (c) presents race within a socio-ecological model of individual, community and society to explain how racism and systemic oppression result in racial health disparities.
4. Our AMA recommends that clinicians and researchers focus on genetics and biology, the experience of racism, and social determinants of health, and not race, when describing risk factors for disease.

Citation: Res. 11, I-20

### **Racial Essentialism in Medicine D-350.981**

1. 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.
2. 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.
3. Our AMA will collaborate with the AAMC, AACOM, NBME, NBOME, ACGME and other appropriate stakeholders, including minority physician organizations and content experts, to identify and address aspects of medical education and board examinations which may perpetuate teachings, assessments, and practices that reinforce institutional and structural racism.
4. 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.

5. Our AMA will support research that promotes antiracist strategies to mitigate algorithmic bias in medicine.

Citation: Res. 10, I-20

**Health Plan Initiatives Addressing Social Determinants of Health H-165.822**

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

Citation: CMS Rep. 7, I-20

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 3  
(A-21)

Introduced by: Gunjan Malhotra, MD; Tani Malhotra, MD; Benjamin Meyer, MD

Subject: Title Change to HOD Policy D-383.996 "Impact of the NLRB Ruling in the Boston Medical Center Case"

Referred to: Reference Committee

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1 Whereas, Titles of AMA policies typically reflect policy content and refrain from citing external  
2 policies, bills, laws or rulings, as these may eventually become irrelevant; and  
3

4 Whereas, Existing AMA Policy D-383.996 "Impact of the NLRB Ruling in the Boston Medical  
5 Center Case," reaffirmed at A-20, cites the "NLRB Ruling" in the title; therefore be it  
6

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

Fiscal Note:

**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

**Impact of the NLRB Ruling in the Boston Medical Center Case D-383.996**

Our AMA: (1) representatives to the ACGME be encouraged to ask the ACGME to review the Institutional Requirements and make recommendations for revisions to address issues related to the potential for resident physicians to be members of labor organizations. This is particularly important as it relates to the section on Resident Support, Benefits, and Conditions of Employment; and (2) through the Division of Graduate Medical Education, the Resident and Fellow Section, and the Private Sector Advocacy Group develop a system to inform resident physicians, housestaff organizations, and employers regarding best practices in labor organizations and negotiations.

Citation: CME Rep. 7, A-00Reaffirmed: CME Rep. 2, A-10Reaffirmed: CME Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 4  
(A-21)

Introduced by: Gunjan Malhotra, MD; Benjamin Meyer, MD

Subject: Opposition to Mid-level Provider Bias Against Physicians and Physician-Led Care

Referred to: Reference Committee

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- 1 Whereas, A survey in 2017 published in Worldviews Evidence Based Nursing revealed that a  
2 majority of the 2,300 nurse respondents did not feel competent in evidence-based practice<sup>1</sup>; and  
3  
4 Whereas, Physicians that speak out about the differences in training received by physicians vs.  
5 by mid-level providers are being fired, labeled “disrespectful” or labeled “not team players” in the  
6 interdisciplinary team treating patients<sup>1</sup>; therefore be it  
7  
8 RESOLVED, That our AMA work with the Liaison Committee on Medical Education (LCME) and  
9 Accreditation Council for Graduate Medical Education (ACGME) to ensure all physician  
10 undergraduate and graduate training programs recognize and teach physicians that they are the  
11 leaders of the healthcare team and are adequately equipped to diagnose and treat patients  
12 independently only because of the intensive, regulated, and standardized education they  
13 receive; and be it further  
14  
15 RESOLVED, That our AMA work with the LCME and ACGME to recognize and eliminate any  
16 bias against physician-led healthcare in all physician training, inter-professional learning and  
17 team building work; and be it further  
18  
19 RESOLVED, That our AMA oppose the false narrative that physicians that seek to protect  
20 patients by preserving physician-led healthcare are being “disrespectful” or “not team players”  
21 and that the only way to “respect” mid-level providers is to equate their training to that of  
22 physicians and support their push for independent practice.

Fiscal Note:

**References:**

1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020.

**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 5  
(A-21)

Introduced by: Gunjan Malhotra, MD; Benjamin Meyer, MD

Subject: Non-Physician Continued Education, Specialty and Subspecialty Training

Referred to: Reference Committee

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1 Whereas, More non-physician post-graduate training programs are being formed across the  
2 nation; there is still no mandatory requirement for non-physicians to pursue post-graduate  
3 training<sup>1</sup>; and  
4

5 Whereas, Physicians are expected to continue to maintain certification by proving they continue  
6 to educate themselves; mid-level providers are not held to the same standard<sup>1</sup>; and  
7

8 Whereas, Currently mid-levels providers can switch between specialties and subspecialties of  
9 medicine and surgery without any formal or regulated training or education<sup>1</sup>; and  
10

11 Whereas, Physicians are limited in their practice abilities by the post-graduate training they  
12 receive<sup>1</sup>; therefore be it  
13

14 RESOLVED, That our AMA study methods to regulate and ensure non-physician post-graduate  
15 training and continued education requirements are rigorous and adequate for the intended field  
16 of practice with physician oversight and to maintain the ability to continue to practice; and be it  
17 further  
18

19 RESOLVED, That our AMA amend policy H-160.949, "Practicing Medicine by Non-Physicians"  
20 by addition to read as follows:  
21

22 (7) work with relevant stakeholders and regulatory agencies to support the  
23 requirement of mandatory postgraduate clinical training for Nurse Practitioners and  
24 Physician Assistants prior to working within a specialty or subspecialty field.  
25

26 (8) work with relevant stakeholders and regulatory agencies to support the  
27 requirement of structured and regulated continued education for Nurse Practitioners  
28 and Physician Assistants in order to continue to maintain certification to practice;  
29 and be it further  
30

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

Fiscal Note:

**References:**

1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020

**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

**Practicing Medicine by Non-Physicians H-160.949**

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

Citation: Res. 317, I-94 Modified by Res. 501, A-97 Appended: Res. 321, I-98 Reaffirmation A-99 Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00 Reaffirmed: CME Rep. 1, I-00 Reaffirmed: CMS Rep. 6, A-10 Reaffirmed: Res. 208, I-10 Reaffirmed: Res. 224, A-11 Reaffirmed: BOT Rep. 9, I-11 Reaffirmed: Res. 107, A-14 Appended: Res. 324, A-14

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 6  
(A-21)

Introduced by: Gunjan Malhotra, MD; Benjamin Meyer, MD

Subject: Preserving Appropriate Physician Supervision of Midlevel Providers and  
Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel  
Providers

Referred to: Reference Committee

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- 1 Whereas, Patients are often not explicitly informed when seeking medical care what the  
2 qualifications are of the person treating them<sup>1</sup>; and  
3  
4 Whereas, Physicians are being forced or coerced into “supervising” midlevel providers either  
5 directly or indirectly, by using it as a requirement for physician employment<sup>1</sup>; and  
6  
7 Whereas, Physicians are being asked to “supervise,” in name only, unreasonably high numbers  
8 of midlevel providers opening them up to liability issues<sup>1</sup>; and  
9  
10 Whereas, There have been instances where physicians’ licenses have been used, unbeknownst  
11 to the physician, to document “supervision” of midlevel providers and also instances where  
12 midlevel providers do not even know the identity of their documented “supervising” physician<sup>1</sup>;  
13 and  
14  
15 Whereas, Midlevel providers/non-physicians have pushed for changes in legislation requiring  
16 “supervision” by physicians be changed to “collaboration” with physicians in effort to equate their  
17 training<sup>1</sup>; therefore be it  
18  
19 RESOLVED, That our AMA advocate that midlevel providers practicing independently without  
20 physician supervision be required to obtain informed consent from patients acknowledging and  
21 understanding that they are not being treated by a physician; and be it further  
22  
23 RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are  
24 notified in writing when their license is being used to “supervise” midlevel providers; and be it  
25 further  
26  
27 RESOLVED, That our AMA advocate for the appropriate supervision of midlevel providers by  
28 physicians as opposed to “collaboration,” which falsely equates non-physician training to that of  
29 physicians; and be it further  
30  
31 RESOLVED, That our AMA oppose mandatory physician supervision of midlevel providers as a  
32 condition for physician employment and in physician employment contracts, especially when  
33 physicians are not provided adequate resources and time for this responsibility; and be it further  
34  
35 RESOLVED, That our AMA advocate for the right of physicians to deny “supervision” to any  
36 midlevel provider whom they deem a danger to patient safety and the ability to report unsafe  
37 care provided by mid-levels to the appropriate regulatory board with whistleblower protections  
38 for physician employment.

Fiscal Note:

**References:**

1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020

**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

**Practicing Medicine by Non-Physicians H-160.949**

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

Citation: Res. 317, I-94 Modified by Res. 501, A-97 Appended: Res. 321, I-98 Reaffirmation A-99 Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00 Reaffirmed: CME Rep. 1, I-00 Reaffirmed: CMS Rep. 6, A-10 Reaffirmed: Res. 208, I-10 Reaffirmed: Res. 224, A-11 Reaffirmed: BOT Rep. 9, I-11 Reaffirmed: Res. 107, A-14 Appended: Res. 324, A-14

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 7  
(A-21)

Introduced by: Gunjan Malhotra, MD; Benjamin Meyer, MD

Subject: Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care

Referred to: Reference Committee

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- 1 Whereas, The book *Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant*  
2 *in Healthcare* by Niran Al-Agba, MD and Rebekah Bernard, MD published in 2020, seeks to  
3 educate patients about the safety of the providers treating them and empower physicians to  
4 regain control of the practice of medicine<sup>1</sup>; and  
5  
6 Whereas, The corporatization of medicine, at the expense of quality, safe healthcare, has led to  
7 physicians being fired and replaced by midlevel providers, especially in states with legislatively  
8 awarded independent practice for midlevel providers<sup>1</sup>; and  
9  
10 Whereas, The corporate practice of medicine has created a situation in which physicians are  
11 expected to “train their replacements”; and  
12  
13 Whereas, Post-graduate programs for midlevel providers expand while physician post-graduate  
14 training programs stay stagnant or close<sup>1</sup>; therefore be it  
15  
16 RESOLVED, That our AMA acknowledge that the corporate practice of medicine has led to  
17 diminished quality of patient care, erosion of the physician-patient relationship, erosion of  
18 physician-driven care, physician burnout, and created a conflict of interest between profit and  
19 training the next generation of physicians needed for our nations physician shortage; and be it  
20 further  
21  
22 RESOLVED, That our AMA work with relevant stakeholders to support and provide legal  
23 resources to physicians who are terminated from employment for speaking out about scope of  
24 practice issues; and be it further  
25  
26 RESOLVED, That our AMA lead a national campaign to educate patients on the value of  
27 physician-led care and about the Dunning-Kruger effect in order to combat the false campaigns  
28 by midlevel providers/non-physicians; and be it further  
29  
30 RESOLVED, That our AMA work with relevant stakeholders to create a physician-reported  
31 database to track and report institutions that replace physicians with midlevel providers and  
32 develop a platform to aid patients in seeking physician-led medical care as opposed to care by  
33 midlevel providers practicing without physician supervision.

Fiscal Note:

References:

1. Al-Agba, Niran, and Rebekah Bernard. *Patients at Risk: the Rise of the Nurse Practitioner and Physician Assistant in Healthcare*. Universal-Publishers, Inc., 2020

**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

**Practicing Medicine by Non-Physicians H-160.949**

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

Citation: Res. 317, I-94 Modified by Res. 501, A-97 Appended: Res. 321, I-98 Reaffirmation A-99 Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00 Reaffirmed: CME Rep. 1, I-00 Reaffirmed: CMS Rep. 6, A-10 Reaffirmed: Res. 208, I-10 Reaffirmed: Res. 224, A-11 Reaffirmed: BOT Rep. 9, I-11 Reaffirmed: Res. 107, A-14 Appended: Res. 324, A-14

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 8  
(A-21)

Introduced by: Gunjan Malhotra, MD; Benjamin Meyer, MD

Subject: Revising the CMS Definition of “Physician”

Referred to: Reference Committee

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- 1 Whereas, The Centers for Medicare and Medicaid Services (CMS) current definition of  
2 “Physician” includes Doctors of Allopathic or Osteopathic medicine, Dental Medicine or Dental  
3 Surgery, Podiatric Medicine, Optometry and Chiropractors<sup>1</sup>; therefore be it  
4  
5 RESOLVED, That our AMA advocate to restrict the CMS definition of “Physician” to only  
6 Allopathic (MD) and Osteopathic (DO) physicians and the international equivalents of these  
7 degrees.

Fiscal Note:

**References:**

1. [https://www.cms.gov/OpenPayments/Glossary-and-Acronyms#:~:text=to%20the%20definition.-,Physician,Insurance%20Program%20\(CHIP\)%20providers%3A&text=Doctors%20of%20Optometry,Chiropractors](https://www.cms.gov/OpenPayments/Glossary-and-Acronyms#:~:text=to%20the%20definition.-,Physician,Insurance%20Program%20(CHIP)%20providers%3A&text=Doctors%20of%20Optometry,Chiropractors)

**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

**Practicing Medicine by Non-Physicians H-160.949**

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education of American Osteopathic Association training program, or have not completed at least one year of accredited post-graduate US medical education.

Citation: Res. 317, I-94 Modified by Res. 501, A-97 Appended: Res. 321, I-98 Reaffirmation A-99 Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00 Reaffirmed: CME Rep. 1, I-00 Reaffirmed: CMS Rep. 6, A-10 Reaffirmed: Res. 208, I-10 Reaffirmed: Res. 224, A-11 Reaffirmed: BOT Rep. 9, I-11 Reaffirmed: Res. 107, A-14 Appended: Res. 324, A-14

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 9  
(A-21)

Introduced by: Amar Kelkar, MD; Ankit Agarwal, MD; Anna Yap, MD; Jacob Quinton, MD

Subject: The Impact of Private Equity on Medical Training

Referred to: Reference Committee

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1 Whereas, The corporate practice of medicine doctrine is an ever-developing set of laws and  
2 rules prohibiting lay corporations from practicing medicine or employing a physician to provide  
3 professional medical services<sup>1</sup>; and  
4

5 Whereas, State corporate practice of medicine laws have numerous loopholes, including  
6 exceptions for professional corporations and for physicians employed by certain healthcare  
7 entities, including, but not limited to, hospitals<sup>1</sup>; and  
8

9 Whereas, Some, but not all, states have explicit laws protecting employed physician autonomy  
10 in clinical decision-making and even among these states there is variability<sup>1</sup>; and  
11

12 Whereas, Retention of physician autonomy in medical practice has been used by private equity  
13 firms and other corporate entities in state-level licensure rulings to determine that physician  
14 employment does not constitute the corporate practice of medicine or violate such laws<sup>1</sup>; and  
15

16 Whereas, Private equity firms are defined as financial organizations that acquire equity in  
17 businesses with funds provided by private investors<sup>2</sup>; and  
18

19 Whereas, There remains little peer-reviewed evidence of the impact of corporate investors and  
20 private equity on physicians, patients, and health care prices<sup>2</sup>; and  
21

22 Whereas, There has been in increasing number of medical practices with majority ownership  
23 from private equity firms, but the degree of investment cannot be precisely determined due to  
24 the common use of nondisclosure agreements<sup>2</sup>; and  
25

26 Whereas, A recent cohort study comparing 204 hospitals acquired by private equity firms from  
27 2005 to 2017 and 532 matched hospitals not acquired by private equity firms demonstrated that  
28 acquired hospitals had subsequent increases in total charges per inpatient days and total  
29 charges compared to costs, and a decrease in Medicaid and Medicare discharges, but  
30 demonstrated improvement in some quality measures<sup>3</sup>; and  
31

32 Whereas, In 2019, the Hahnemann Medical Center, a safety net hospital in Philadelphia,  
33 declared bankruptcy and a consortium of hospitals submitted a winning bid of \$55 million for  
34 550 government-funded residency slots<sup>4</sup>, thus demonstrating a naked attempt at private equity  
35 seeking to control Graduate Medical Education (GME) training positions; and  
36

37 Whereas, Section 5506 of the Affordable Care Act addressed the issue of “lost” resident cap  
38 positions due to teaching hospital closure by instructing the U.S. Secretary of Health and  
39 Human Services to establish a process by regulation that would redistribute slots from teaching

1 hospitals that close to hospitals that meet certain criteria<sup>5</sup>, though there is limited public data to  
2 show where these positions are redistributed to; and

3  
4 Whereas, Geographic inequity in where direct and indirect GME monies flow, relative to where  
5 they are needed<sup>4</sup>, may contribute to hospital systems seeking alternative sources of funding to  
6 expand GME positions; and

7  
8 Whereas, The AMA has only peripherally addressed protections for physicians in training  
9 related to the corporate practice of medicine, recommending, “that physicians in training should  
10 not be asked to sign covenants not to compete as a condition of entry into any residency or  
11 fellowship program”<sup>6</sup>; and

12  
13 Whereas, GME training positions created by private equity funding have been increasing in  
14 recent years in multiple specialties, most notably emergency medicine, but there is little  
15 published on the subject; and

16  
17 Whereas, Medical trainees do not have the same ability as practicing physicians to negotiate or  
18 protect themselves from the potential involvement or influence of corporate investors or private  
19 equity in their education; and

20  
21 Whereas, The creation of additional GME positions in specialties without consideration of post-  
22 training positions may lead to further imbalanced<sup>7</sup> physician market inefficiencies wherein too  
23 many physicians are trained in some specialties, while other specialties see continued or  
24 worsened existing physician shortages; therefore be it

25  
26 RESOLVED, That our AMA work with relevant stakeholders including specialty societies and  
27 the ACGME to study the level of financial involvement and influence on medical practice and  
28 education of private equity firms in graduate medical education training programs and report  
29 back at I-21 with concurrent publication of their findings in a peer-reviewed journal; and be it  
30 further

31  
32 RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at  
33 the June 2021 Special Meeting of the HOD.

Fiscal Note:

#### References:

1. AMA Issue Brief: Corporate Practice of Medicine. Originally published 2019. Accessed 04/14/2021 at <<https://www.ama-assn.org/media/7661/download>>.
2. AMA Issue Brief: Corporate Investors. Originally published 2019. Accessed 04/14/2021 at <<https://www.ama-assn.org/system/files/2019-12/issue-brief-corporate-investors.pdf>>.
3. Bruch JD, Gondi S, Song Z. Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition. JAMA Intern Med. 2020;180(11):1428-1435. doi:10.1001/jamainternmed.2020.3552.
4. Grischkan JA, Friedman AB, Chandra A. Moving the Financing of Graduate Medical Education Into the 21st Century. JAMA. 2020;324(11):1035-1036. doi:10.1001/jama.2020.15480.
5. CMS: Medicare Fact Sheet on Displaced Residents Due to Program or Hospital Closure. Originally published 07/2019. Accessed 04/19/2021 at <<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Fact-sheet-displaced-residents.pdf>>.
6. AMA Code of Medical Ethics Opinion 11.2.3.1
7. Chandra A, Khullar D, Wilensky GR. The Economics of Graduate Medical Education. N Engl J Med 2014; 370:2357-2360. doi: 10.1056/NEJMp1402468.

#### Relevant AMA Policy:

##### Corporate Investors H-160.891

1.Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:

- a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
  - b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
  - c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
  - d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
  - e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
  - f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
  - g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
  - h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
  - i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
  3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
  4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

Citation: CMS Rep. 11, A-19

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 10  
(A-21)

Introduced by: Steven Young, MD

Subject: Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs

Referred to: Reference Committee

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1 Whereas, USMLE fees are steep as a US medical student: Step 1 \$645, Step 2 \$645<sup>1,2</sup>; and  
2  
3 Whereas, USMLE fees are even higher for International Medical Graduates (IMGs): Step 1  
4 \$975, Step 2 \$975<sup>3</sup>; and  
5  
6 Whereas, If a medical student takes the USMLE Step 1 or 2 exams outside the US, there is an  
7 additional delivery fee of the electronic test of \$180 for Step 1 and \$200 for Step 2<sup>4</sup>; and  
8  
9 Whereas, In 2020, over 52,000 US MD/DO and IMG applicants applied to residencies (over  
10 \$38M for US MD/DO med students and over \$40M for IMGs in USMLE Step 1 and 2 fees)<sup>5</sup>; and  
11  
12 Whereas, In 2018, 21,393 graduates applied for Educational Commission for Foreign Medical  
13 Graduates (ECFMG) certification and only 9,431 were certified<sup>6</sup>; and  
14  
15 Whereas, ECFMG certification (\$60 in 2013; \$150 in 2021) is required to take USMLE Step 3  
16 for IMGs: primary source of verification of credentials (\$60) + passing USMLE exams<sup>3,7</sup>; and  
17  
18 Whereas, In 2019, IMGs constituted 22% of physicians in training in residency, yet their costs to  
19 apply to become physicians in the US is much greater than their US counterparts<sup>8</sup>; and  
20  
21 Whereas, During the COVID-19 pandemic and suspension of USMLE Step 2 CS, ECFMG  
22 required IMGs to pass an Occupational English Test (OET) (\$444) (online courses available for  
23 purchase from official OET sites), if students fit within 5 defined pathways (\$900)<sup>9,10</sup>; and  
24  
25 Whereas, Prior to the cancellation of the USMLE Step 2 CS exam, examination fees rose year  
26 after year, but even more so for IMGs (~ \$1600 in 2020, up from ~\$1420 in 2013) compared to  
27 US counterparts (~ \$1280 in 2020, up from ~\$1200 in 2013)<sup>11</sup>; and  
28  
29 Whereas, ECFMG also provides an alternative way to verify credentials through Electronic  
30 Portfolio of International Credentials (EPIC) that costs \$130 (\$125 in 2020) and \$100 (\$90 in  
31 2020) to confirm each credential and costs \$50 to deliver each subsequent EPIC report<sup>12</sup>; and  
32  
33 Whereas, The ECFMG net assets in 2018 were \$151,818,498<sup>13</sup>; therefore be it  
34  
35 RESOLVED, That our AMA work with the ACGME, NBME, ECFMG, FSMB, and other relevant  
36 stakeholders to reduce application, exam, licensing fees and related financial burdens for IMGs.

Fiscal Note:

References:

1. <https://www.fsmb.org/step-3/step-3-application-fees/>. Accessed Mar 26, 2021
2. <https://www.usmle.org/apply/index.html>. Accessed Mar 26, 2021
3. <https://www.ecfm.org/fees/index.html>. Accessed Mar 26, 2021
4. <https://www.ecfm.org/fees/usmle-surcharge.html>. Accessed Mar 26, 2021
5. <https://www.aamc.org/media/6171/download>. Accessed Mar 26, 2021
6. <https://www.ecfm.org/forms/factcard.pdf>. Accessed Mar 26, 2021
7. <https://www.ecfm.org/certification/index.html>. Accessed Mar 26, 2021
8. <https://www.ecfm.org/certification/imgs-united-states.html>. Accessed Mar 26, 2021
9. <https://www.ecfm.org/certification-requirements-2021-match/oet.html>. Accessed Mar 26, 2021
10. <https://www.occupationalenglishtest.org/book-oet/>. Accessed Mar 26, 2021
11. <https://thesheriffsof sodium.com/2020/08/30/ecfm-finances-part-ii-by-the-numbers/>. Accessed Mar 26, 2021
12. <http://www.ecfmgepic.org/fees.html>. Accessed Mar 26, 2021
13. <https://thesheriffsof sodium.com/2020/08/30/ecfm-finances-part-ii-by-the-numbers/>. Accessed Mar 26, 2021

#### **Relevant RFS Position Statements:**

#### **Relevant AMA Policy:**

#### **Retirement of the National Board of Medical Examiners Step 2 Clinical Skills Exam for US Medical Graduates: Call for Expedited Action by the American Medical Association D-275.950**

Our AMA: (1) will take immediate, expedited action to encourage the National Board of Medical Examiners (NBME), Federation of State Medical Boards (FSMB), and National Board of Osteopathic Medical Examiners (NBOME) to eliminate centralized clinical skills examinations used as a part of state licensure, including the USMLE Step 2 Clinical Skills Exam and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 - Performance Evaluation Exam; (2) in collaboration with the Educational Commission for Foreign Medical Graduates (ECFMG), will advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency; (3) strongly encourages all state delegations in the AMA House of Delegates and other interested member organizations of the AMA to engage their respective state medical licensing boards, the Federation of State Medical Boards, their medical schools and other interested credentialing bodies to encourage the elimination of these centralized, costly and low-value exams; and (4) will advocate that any replacement examination mechanisms be instituted immediately in lieu of resuming existing USMLE Step 2-CS and COMLEX Level 2-PE examinations when the COVID-19 restrictions subside.

Citation: Res. 306, I-20

#### **AMA Principles on International Medical Graduates H-255.988**

##### **Our AMA supports:**

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
7. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
8. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.

9. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
  10. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
  11. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
  12. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
  13. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
  14. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.
  15. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.
  16. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.
  17. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
  18. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
  19. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
  20. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
  21. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
  22. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
- Citation: BOT Rep. Z, A-86Reaffirmed: Res. 312, I-93Modified: CME Rep. 2, A-03Reaffirmation I-11Reaffirmed: CME Rep. 1, I-13Modified: BOT Rep. 25, A-15Modified: CME Rep. 01, A-16Appended: Res. 304, A-17Modified: CME Rep. 01, I-17Reaffirmation: A-19

### **Abolish Discrimination in Licensure of IMGs H-255.966**

#### Medical Licensure of International Medical Graduates

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):

A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.

B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

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

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

Citation: BOT Rep. 25, A-15

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 11  
(A-21)

Introduced by: Emma York, DO; Rock Vomer, DO, DPT

Subject: Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education

Referred to: Reference Committee

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- 1 Whereas, Musculoskeletal (MSK) disorders are estimated to affect 126.6 million American  
2 adults and result in \$874 billion in annual treatment cost, lost wages, and healthcare visits<sup>6</sup>; and  
3  
4 Whereas, MSK conditions account for more than 50 percent of disabling conditions reported by  
5 Americans<sup>7</sup>; and  
6  
7 Whereas, Disorders of the MSK system remain among the primary reasons that individuals visit  
8 healthcare providers in the United States accounting for approximately 20 percent of visits to  
9 emergency departments and primary care clinics<sup>7</sup>; and  
10  
11 Whereas, MSK complaints are the second leading cause for patients to go to primary care  
12 clinics<sup>8</sup>; and  
13  
14 Whereas, A survey of 300 primary care physicians reported that 30-40% of their case load  
15 involved MSK complaints<sup>7</sup>; and  
16  
17 Whereas, It is expected that 60-70% of adults will experience low back pain in their lifetime and  
18 one in four adults in the United States experience at least one day of back pain in a three-month  
19 period<sup>14</sup>; and  
20  
21 Whereas, One in four graduates of United States medical schools are graduates of Osteopathic  
22 Medical Schools<sup>5</sup>; and  
23  
24 Whereas, 40,084 applicants applied to the National Resident Match Program<sup>15</sup> in 2020, of which  
25 10,034, including both osteopathic and allopathic students, matched into primary care  
26 specialties including Family Medicine, Internal Medicine and Pediatrics<sup>15</sup>; and  
27  
28 Whereas, As few as only 15% of allopathic schools have required MSK clinical instruction and  
29 MSK selective rotations were only offered at 34% of medical schools<sup>9</sup>; and  
30  
31 Whereas, Only 2% of current medical school curricula is dedicated to MSK education<sup>1</sup>; and  
32  
33 Whereas, Students attending Osteopathic Medical Schools receive an additional 200 hours of  
34 hands-on MSK training, in comparison to Allopathic schools, through education on Osteopathic  
35 Manual Therapy<sup>12</sup>; and  
36  
37 Whereas, According to the Association of American Medical Colleges (AAMC), Only 58% of  
38 medical schools have required clerkships in the category of "Introduction to Physical Diagnosis"

1 and AAMC does not include physical exam skills as a “Medical School Program Expectation” for  
2 grading competency of medical students<sup>9</sup>; and

3  
4 Whereas, The AMA Council on Medical Education previously passed a resolution to support the  
5 discussion of formal means of communication between allopathic and osteopathic medical  
6 education communities to better align allopathic and osteopathic education policies and  
7 practices; and

8  
9 Whereas, Family medicine residents are required to have at least 200 hours, or two months,  
10 dedicated to the care of patients with a variety of MSK problems and the Internal Medicine  
11 Accreditation Council for Graduate Medical Education curriculum requirements do not require  
12 rotations in sports medicine or orthopedics or didactic education for trainees on MSK  
13 medicine<sup>3,4</sup>; and

14  
15 Whereas, Osteopathic Manual Therapy techniques also known as manual therapy techniques  
16 have been used by physicians, physical therapists and chiropractors for MSK pain with  
17 evidence to support its efficacy<sup>6</sup>; and

18  
19 Whereas, In multiple blinded randomized controlled trials studying the effect of Osteopathic  
20 Manual Therapy on low back pain, Osteopathic Manual Therapy significantly reduced low back  
21 pain<sup>13</sup>; and

22  
23 Whereas, Osteopathic Medical Therapy, including spinal manipulation, is now a recommended  
24 first line treatment modality for low back pain<sup>2</sup>; and

25  
26 Whereas, Inclusion of Osteopathic Manual Therapy in treatment plans for low back pain when  
27 studied have resulted in 18.5% fewer prescriptions written, 74.2% fewer x-rays ordered, 76.9%  
28 fewer referrals to other providers and 90% fewer magnetic resonance imaging scans ordered<sup>10</sup>;  
29 and

30  
31 Whereas, The AMA has supported prior resolutions that have helped Osteopathic students,  
32 trainees and physicians to be viewed equally to their Allopathic counterparts in the work place;  
33 and

34  
35 Whereas, Including Osteopathic Manual Therapy education in Allopathic medical schools would  
36 increase the total number of MSK education hours of Allopathic physicians and increase their  
37 understanding of their Osteopathic colleagues’ training; and

38  
39 Whereas, Incorporating Osteopathic Manual Therapy education in primary care residency  
40 training programs, including family medicine, internal medicine, and pediatrics programs, would  
41 increase the total number of MSK education training hours residents receive and increase  
42 allopathic resident physicians’ understanding of their Osteopathic colleagues’ training; therefore  
43 be it

44  
45 RESOLVED, That our American Medical Association advocate to the Liaison Committee on  
46 Medical Education and other relevant stakeholders for the incorporation of Osteopathic Manual  
47 Therapy into the education curriculum of allopathic schools in the United States; and be it  
48 further

49  
50 RESOLVED, That our AMA advocate to the Accreditation Council for Graduate Medical  
51 Education and other relevant stakeholders for the incorporation of Osteopathic Manual Therapy

1 into the education curriculum of all primary care residency training programs in the United  
2 States; and be it further

3  
4 RESOLVED, That our AMA continue to support equal treatment of osteopathic students,  
5 trainees and physicians in the residency application cycle and workplace through continued  
6 education on the training of Osteopathic physicians.

Fiscal Note:

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**Relevant RFS Position Statements:**

**295.009R Improving Patient Safety Through Collaboration in Resident and Fellow Education:** That our AMA partner with stakeholder organizations including the ACGME (Accreditation Council on Graduate Medical Education) and AOA (American Osteopathic Association) to encourage partnership in the development and revision of residency and fellowship accreditation standards in order to better align the education experience of allopathic and osteopathic residents and fellows with the overall goal of assuring patient safety. (Resolution 5, A-12)

**Relevant AMA Policy:**

**Equal Fees for Osteopathic and Allopathic Medical Students H-295.876**

1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training.
2. Our AMA encourages equitable fees for allopathic and osteopathic medical students in access to clinical electives, while respecting the rights of individual allopathic and osteopathic medical schools to set their own policies related to visiting students.
3. Our AMA will work with relevant stakeholders to explore reasons behind application barriers that result in discrimination against osteopathic medical students when applying to elective visiting clinical rotations, and generate a report with the findings by the 2020 Interim Meeting.

Citation: Res. 809, I-05 Appended: CME Rep. 6, A-07 Modified: CCB/CLRPD Rep. 2, A-14 Appended: Res. 2020, I-19.

**AMA Membership Strategy: Osteopathic Medicine G-635.053**

- Our AMA's membership strategy on osteopathic physicians (DOs) includes the following: Our AMA: (1) encourages all state societies to accept DOs as members at every level of the Federation; (2) encourages state societies with schools of osteopathic medicine to support development of Medical Student Sections at those schools; Both the MSS Governing Council and existing MSS chapters in states with osteopathic schools should assist in this effort; (3) encourages that DO members of our AMA continue to participate in the Membership Outreach program; (4) will provide recruiters with targeted lists of DO nonmembers upon request; (5) will include DOs, as appropriate, in direct nonmember mailings; and (6) will expand its database of information on osteopathic students and doctors.

Citation: BOT Rep. 1-93-11 Consolidated: CLRPD Rep. 3, I-01 Reaffirmed: Res. 809, I-05 Reaffirmed: BOT Rep. 35, A-08 Modified: CCB/CLRPD Rep. 3, A-12.

**Encouragement of Interprofessional Education Among Health Care Professions Students D-295.934**

Our AMA supports the concept that medical education should prepare students for practice in physician-led interprofessional teams.

Citation: Res 308, A-08 Appended: CME Rep. 1, I-12.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 12  
(A-21)

Introduced by: Raisa Tikhtman, MD; Kelly C. Landeen, MD; Michal Trope, MD

Subject: Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer

Referred to: Reference Committee

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1 Whereas, The annual incidence of human papilloma virus (HPV)-associated oropharyngeal  
2 squamous cell carcinoma (OPSCC) in the United States has risen steadily over the past several  
3 decades<sup>1</sup>; and  
4  
5 Whereas, The majority of new OPSCC diagnoses are associated with underlying oropharyngeal  
6 HPV infection<sup>1</sup>; and  
7  
8 Whereas, OPSCC now accounts for the largest burden of HPV-associated cancer diagnoses in  
9 the United States, with over 80% of cases occurring in men<sup>2</sup>; and  
10  
11 Whereas, HPV-16 accounts for 90 to 95% of HPV-associated OPSCC<sup>3</sup>; and  
12  
13 Whereas, All Food and Drug Administration-approved HPV vaccines demonstrate efficacy  
14 against HPV-16<sup>3</sup>; and  
15  
16 Whereas, While HPV vaccination rates are overall improving, only 54.2% of adolescents aged  
17 13-17 years had completed the HPV vaccine series in 2019<sup>4</sup>; and  
18  
19 Whereas, Despite equivalent vaccine schedule recommendations from the Centers for Disease  
20 Control and Prevention, vaccine uptake among males remains lower than females<sup>5</sup>; and  
21  
22 Whereas, Awareness regarding the association between HPV infection and OPSCC remains  
23 low among pediatricians, and public awareness is minimal, with only 0.8% of respondents in an  
24 online survey of 2,126 adults identifying HPV as a risk factor for mouth and throat cancer<sup>6,7</sup>; and  
25  
26 Whereas, The strength and comprehensiveness of the healthcare provider's recommendation  
27 are frequently cited as key factors influencing both parents and adult patients to pursue HPV  
28 vaccination<sup>8-11</sup>; and  
29  
30 Whereas, There is no evidence-based screening test available for OPSCC; and  
31  
32 Whereas, Our AMA supports increased physician and public awareness about HPV-associated  
33 diseases, as well as the availability of the HPV vaccine (policy H-440.872); therefore be it  
34  
35 RESOLVED, That our AMA-RFS support efforts to increase rates of HPV vaccination among  
36 males and females; and be it further  
37

- 1 RESOLVED, That our AMA-RFS support efforts to increase physician awareness of HPV-  
2 associated OPSCC and to develop comprehensive training in HPV vaccine counseling relevant  
3 to all stakeholders; and be it further  
4  
5 RESOLVED, That our AMA support efforts to enhance awareness in the general public  
6 regarding the association between HPV infection and OPSCC; and be it further  
7  
8 RESOLVED, That our AMA support increased efforts for the development of OPSCC screening  
9 tools.

Fiscal Note:

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**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

**HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872**

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV 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 HPV 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.

Citation: Res. 503, A-07Appended: Res. 6, A-12

#### **Human Papillomavirus (HPV) Inclusion in our School Education Curricula D-170.995**

Our AMA will: (1) strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in all genders, the causal relationship of HPV to cancer and genital lesions, and the importance of routine pap tests in the early detection of cancer; (2) urge that students and parents be educated about HPV and the availability of the HPV vaccine; and (3) support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers.

Citation: Res. 418, A-06Reaffirmed: CSAPH Rep. 01, A-16Modified: Res. 404, A-18

#### **Insurance Coverage for HPV Vaccine D-440.955**

Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices; (2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.

Citation: Res. 818, I-06Reaffirmed: CMS Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 13  
(A-21)

Introduced by: RFS Committee on Business and Economics

Subject: COVID-19 Vaccination Rollout to Emergency Departments and Urgent Cares

Referred to: Reference Committee

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- 1 Whereas, The vaccination rollout has marginalized some of our nation's most vulnerable  
2 populations<sup>1</sup>; and  
3
- 4 Whereas, The AMA has recognized the utility of advocating for the vaccine to be in the hands of  
5 physician offices<sup>2</sup>; and  
6
- 7 Whereas, Emergency departments (EDs) disproportionately see high rates of patients who are  
8 poor, elderly, individuals of color, immigrants, patients with disabilities, and patients with  
9 significant comorbidities<sup>3</sup>; and  
10
- 11 Whereas, EDs and urgent cares (UCs) already handle vaccination programs successfully such  
12 as the annual influenza vaccine and the Tdap vaccine; and  
13
- 14 Whereas, EDs and UCs have the capacity to deal with short observations after vaccine  
15 administrations and are equipped to acutely treat allergic reactions if they occur; and  
16
- 17 Whereas, Allowing the vaccine to be in the hands of physicians in the ED and UC settings  
18 allows physicians to actively engage vaccine-hesitant patients and provide them with accurate  
19 information; and  
20
- 21 Whereas, A recent focus group highlighted that “doctors are far better messengers than  
22 politicians, celebrities, or the media” when it comes the personal decision of getting the vaccine  
23 or not and maybe one of the only ways to significantly change the minds of the vaccine  
24 hesitant<sup>4</sup>; and  
25
- 26 Whereas, The current Administration has acknowledged the need to “meet people where they  
27 are” and have begun to distribute vaccines to places such as dialysis centers that  
28 disproportionately serve vulnerable populations, but have yet to acknowledge the need to  
29 distribute to EDs and UCs<sup>5</sup>; and  
30
- 31 Whereas, Some organized medicine groups have already acknowledged the need to distribute  
32 vaccines to EDs and have even created basic educational material on how to set up an ED-  
33 based vaccination program<sup>6</sup>; therefore be it  
34
- 35 RESOLVED, That our AMA acknowledge that our nation's vaccine rollout is not yet optimized,  
36 and we have a duty to vaccinate as many people in an effective manner; and be it further  
37
- 38 RESOLVED, That our AMA lobby the current Administration for the distribution of vaccinations  
39 to our nation's emergency departments and urgent cares; and be it further  
40

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

Fiscal Note:

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**Relevant AMA Policy:**

**An Urgent Initiative to Support COVID-19 Vaccination Programs D-440.921**

Our AMA will institute a program to promote the integrity of a COVID-19 vaccination program by: (1) educating physicians on speaking with patients about COVID-19 vaccination, bearing in mind the historical context of "experimentation" with vaccines and other medication in communities of color, and providing physicians with culturally appropriate patient education materials; (2) educating the public about the safety and efficacy of COVID-19 vaccines, by countering misinformation and building public confidence; (3) forming a coalition of health care and public health organizations inclusive of those respected in communities of color committed to developing and implementing a joint public education program promoting the facts about, promoting the need for, and encouraging the acceptance of COVID-19 vaccination; and (4) supporting ongoing monitoring of COVID-19 vaccines to ensure that the evidence continues to support safe and effective use of vaccines among recommended populations.

Citation: Res. 408, I-20

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 14  
(A-21)

Introduced by: RFS Committee on Business and Economics

Subject: Expanding the AMA's Study on the Economic Impact of COVID-19

Referred to: Reference Committee

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1 Whereas, The 2019 Coronavirus Disease (COVID-19) pandemic has had a large impact on  
2 healthcare spending, utilization, and employment; and  
3

4 Whereas, The American healthcare system and hospital revenue drastically declined as a result  
5 of COVID-19, experiencing monthly financial losses on average exceeding \$50 billion dollars  
6 during the earliest months of the COVID-19 pandemic;<sup>1</sup> and  
7

8 Whereas, It has been estimated that the cancellation of elective surgeries and procedures as a  
9 result of the COVID-19 pandemic could cost the healthcare system and hospitals \$20-50 billion  
10 in revenue each month, with monthly net income losses exceeding \$5 billion dollars<sup>1,2,3</sup>; and  
11

12 Whereas, The economic support for offsetting the financial strain of the COVID-19 pandemic  
13 that was provided by the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act  
14 likely disadvantaged healthcare systems treating at-risk populations because it initially used a  
15 formula based on Medicare fee-for-service billings to distribute financial aid to hospitals<sup>3,4</sup>; and  
16

17 Whereas, Urban and rural hospitals, and other medical centers that disproportionately treat  
18 underserved populations may face higher existential threats due to lost revenue, higher costs,  
19 and other the economic burdens incurred during the COVID-19 pandemic<sup>3,5</sup>; and  
20

21 Whereas, The economic impact on residents and fellows seems to have been significant  
22 regarding job loss<sup>6</sup>; and  
23

24 Whereas, The AMA has become a predominant source of information regarding the economic  
25 impact on physicians and their practices during the COVID-19 pandemic<sup>7,8</sup>; and  
26

27 Whereas, The AMA has yet to study how the economic impact of the COVID-19 pandemic on  
28 hospitals, clinics, surgeons, students, residents, fellows, and patients with respect to lost  
29 revenue and unanticipated healthcare costs; therefore be it  
30

31 RESOLVED, That our AMA study the economic impact of the COVID-19 pandemic in order to  
32 identify and better understand groups of physicians and patients that may have been  
33 disproportionately affected by the financial burdens of the COVID-19 pandemic; and be it further  
34

35 RESOLVED, that our AMA work with relevant organizations and stakeholders to study the long-  
36 term economic recovery of healthcare institutions including how the financial solvency and  
37 existential security of public, private, and other healthcare institutions across the country have  
38 been affected by lost revenues and unanticipated costs incurred during the COVID-19  
39 pandemic.

## Fiscal Note:

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### Relevant RFS Position Statements:

#### **Addressing the Physician Workforce Shortage by Increasing GME Funding 170.009R**

That our AMA-RFS: (1) work with the AMA and in consultation with interested stakeholders to develop a comprehensive framework for a sustainable GME financing plan that addresses the physician workforce shortage and could be implemented at both the state and federal levels; and (2) work with the AMA to support pilot projects supported through state and federal funding in medically under-served areas that foster resident training programs, offer loan repayment, and support independent practice development  
AMA-RFS Digest of Actions 19 as a means to address the physician workforce shortage. (Late Resolution 1, A-13) [CME Report 5, I-13]

#### **Making GME Financing and Reform a Priority for AMA 280.002R**

That our AMA recognize that funding for and distribution of positions for graduate medical education (GME) are in crisis in the United States and that meaningful and comprehensive reform is urgently needed. Additionally, that our AMA immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda. (Resolution 6, I11)

#### **Maintaining Financial Solvency During Residency Training 281.010R**

Recommended that our AMA-RFS: (1) encourage resident physicians to work with hospitals and universities to examine the issue of student loan indebtedness and possible solutions including increased compensation packages; (2) continue to work with the AMA to encourage resident physicians to inform legislators of the impact of financing graduate medical education on career choice, specialty choice, and practice location; and (3) report to the Assembly on the results of the survey of medical students being conducted by the AMA.

### Relevant AMA Policy:

#### **Physician Payment Advocacy for Additional Work and Expenses Involved in Treating Patients During the Covid-19 Pandemic and Future Public Health Emergencies D-390.947**

Our AMA: (1) will work with interested national medical specialty societies and state medical associations to advocate for regulatory action on the part of the Centers for Medicare & Medicaid Services to implement a professional services payment enhancement, similar to the HRSA COVID-19 Uninsured Program, to be drawn from additional funds appropriated for the public health emergency to recognize the

additional uncompensated costs associated with COVID-19 incurred by physicians during the COVID-19 Public Health Emergency; (2) will work with interested national medical specialty societies and state medical associations to continue to advocate that the Centers for Medicare & Medicaid Services and private health plans compensate physicians for the additional work and expenses involved in treating patients during a public health emergency, and that any new payments be exempt from budget neutrality; and (3) encourages interested parties to work in the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) processes to continue to develop coding and payment solutions for the additional work and expenses involved in treating patients during a public health emergency.

Citation: Res. 114, I-20

**Creating a Congressionally-Mandated Bipartisan Commission to Examine the U.S. Preparations for and Response to the COVID-19 Pandemic to Inform Future Efforts D-440.923**

1. Our AMA will advocate for passage of federal legislation to create a congressionally-mandated bipartisan commission composed of scientists, physicians with expertise in pandemic preparedness and response, public health experts, legislators and other stakeholders, which is to examine the U.S. preparations for and response to the COVID-19 pandemic, in order to inform and support future public policy and health systems preparedness.

2. In advocating for legislation to create a congressionally-mandated bipartisan commission, our AMA will seek to ensure key provisions are included, namely that the delivery of a specific end product (i.e., a report) is required by the commission by a certain period of time, and that adequate funding be provided in order for the commission to complete its deliverables.

Citation: Res. 211, I-20

**Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953**

In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.

Citation: Res. 202, I-20

**Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-385.951**

Our AMA and the federation of medicine will work to improve and expand various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist physicians in response to the Covid-19 pandemic, including:

- Restarting the suspended Medicare Advance payment program, including significantly reducing the re-payment interest rate and lengthening the repayment period;
- Expanding the CARES Act health care provider relief pool and working to ensure that a significant share of the funding from this pool is made available to physicians in need regardless of the type of patients treated by those physicians; and
- Reforming the Paycheck Protection Program, to ensure greater flexibility in how such funds are spent and lengthening the repayment period.

Citation: Res. 202, I-20

**Crisis Payment Reform Advocacy D-405.979**

Our AMA will continue to promote national awareness of the loss of physician medical practices and patient access to care due to COVID-19, and continue to advocate for reforms that support and sustain physician medical practices.

Citation: Res. 218, I-20

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 15  
(A-21)

Introduced by: Kelley Butler, MD, MPH; Dayna Isaacs, MD, MPH

Subject: Fulfilling Medicine’s Social Contract with Humanity in the Face of the Climate Health Crisis

Referred to: Reference Committee

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1 Whereas, The Lancet Countdown on health and climate change has warned that “a rapidly  
2 changing climate has dire implications for every aspect of human life, exposing vulnerable  
3 populations to extremes of weather, altering patterns of infectious disease, and compromising  
4 food security, safe drinking water, and clean air”<sup>1</sup> earning it the title of the “greatest public health  
5 challenge of the 21st century”<sup>2</sup>; and  
6

7 Whereas, Human activities since the Industrial Revolution resulting in burning fossil fuels like  
8 coal and oil have increased the concentration of atmospheric carbon dioxide levels<sup>3</sup> higher than  
9 ever before since the evolution of homo sapiens<sup>4</sup>; and  
10

11 Whereas, At least 250,000 additional deaths are anticipated annually between 2030 and 2050  
12 from heat exposure in the elderly, diarrhea, malaria, and childhood malnutrition alone<sup>5</sup>, without  
13 factoring in the myriad of other ways that climate change acts as a health risk multiplier; and  
14

15 Whereas, Despite the landmark Paris Agreement in 2016, when countries committed to limit  
16 global warming to “well below 2°C,” global carbon dioxide (CO<sub>2</sub>) emissions continue to rise  
17 steadily<sup>6</sup>, with no convincing or sustained abatement; and  
18

19 Whereas, Humans have already caused a rise in the global average temperature of 1.2°C and  
20 our changing climate is already producing considerable shifts in the underlying social and  
21 environmental determinants of health at the global level<sup>7</sup>; and  
22

23 Whereas, People and communities are differentially exposed to hazards and disproportionately  
24 affected by climate-related health risks; for example, some populations might experience  
25 increased climate risks due to a combination of exposure and sensitivity, such as outdoor  
26 workers<sup>8</sup>, communities disproportionately burdened by poor environmental quality<sup>9</sup>, and some  
27 communities in the rural Southeastern United States<sup>10</sup>; and  
28

29 Whereas, Across all climate risks, children, older adults, low-income communities, some  
30 communities of color, and those experiencing discrimination are disproportionately affected by  
31 extreme weather and climate events, partially because they are often excluded in planning  
32 processes<sup>11</sup>; and  
33

34 Whereas, According to the latest available science, in order to limit warming to 1.5°C and  
35 achieve the Paris Agreement goals would require global greenhouse gas (GHG) emissions to  
36 have peaked by 2020 and be reduced to zero by around 2050<sup>12</sup>; thus we have a vanishing  
37 window of opportunity for meaningful action; and  
38

1 Whereas, Many climate change mitigation interventions have immediate local air quality  
2 benefits, among others, and thus immediate health co-benefits<sup>13</sup>; and  
3

4 Whereas, Cutting GHG emissions “may appear to be difficult and costly, but its near-term  
5 benefits outweigh its costs in many areas<sup>14</sup>; and  
6

7 Whereas, It is estimated that worldwide 10.2 million premature deaths annually are attributable  
8 to the fossil-fuel component of PM2.5, constituting nearly 18% of premature deaths<sup>15</sup>; and  
9

10 Whereas, Worldwide, tobacco use causes more than seven million deaths per year<sup>16</sup>; and  
11

12 Whereas, Our AMA has extensive policy to organize physician leadership vis a vis tobacco’s  
13 public health harms<sup>17</sup>; and  
14

15 Whereas, the Tobacco Industry and Fossil Fuel Industry business models are similar in that  
16 their products are incongruous with the interests of public health and their profit interests  
17 motivate well-funded misinformation campaigns<sup>18</sup>; and  
18

19 Whereas, “The strategy, tactics, infrastructure, and rhetorical arguments and techniques used  
20 by fossil fuel interests to challenge the scientific evidence of climate change—including cherry  
21 picking, fake experts, and conspiracy theories—come straight out of the Tobacco Industry’s  
22 playbook for delaying tobacco control”<sup>19</sup>; and  
23

24 Whereas, Physicians are uniquely trusted messengers, with a unique responsibility to advocate  
25 politically for policies to safeguard health in the face of any public health crisis, whether the  
26 COVID-19 pandemic or the climate crisis, in order to build social will for science-based policy  
27 action; and  
28

29 Whereas, Our AMA has adopted multiple policies addressing climate change (H-135.919, H-  
30 135.938, H-135.977, H-135.923, D-135.968, D-135.969, H-135.973), but these policies fall short  
31 of coordinating strategic physician advocacy leadership on the scale necessary for such a  
32 health crisis; and  
33

34 Whereas, In the face of the existential threat that the climate crisis poses, the aforementioned  
35 policies have not been leveraged to fulfill our AMA’s Declaration of Professional Responsibility  
36 (H-140.900) which states, “We, the members of the world community of physicians, solemnly  
37 commit ourselves to ‘Medicine’s Social Contract with Humanity’ in order to continue to earn  
38 society’s trust in the healing profession, by, among other oaths, promising that we will ‘Educate  
39 the public and polity about present and future threats to the health of humanity’”; and  
40

41 Whereas, Our AMA has no identified longitudinal body or Center for coordinating and  
42 centralizing the Association’s efforts to address climate change which the WHO calls “...the  
43 greatest threat to global health in the 21st century”<sup>20</sup>; and  
44

45 Whereas, our AMA Corporate Policies on Tobacco H-500.975: resolved that (1) Our AMA: (a)  
46 continues to urge the federal government to reduce and control the use of tobacco and tobacco  
47 products; (b) supports developing an appropriate body for coordinating and centralizing the  
48 Association’s efforts toward a tobacco-free society; and (c) will defend vigorously all attacks by  
49 the tobacco industry on the scientific integrity of AMA publications; therefore be it  
50

1 RESOLVED, that our AMA advocate at all levels of government for equitable policies to  
2 transition rapidly away from the use of coal, oil and natural gas to clean, safe, and renewable  
3 energy and energy efficiency; and be it further  
4

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

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**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

**Climate Change Education Across the Medical Education Continuum H-135.919**

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of

climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

Citation: Res. 302, A-19

#### **Global Climate Change and Human Health H-135.938**

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

Citation: CSAPH Rep. 3, I-08Reaffirmation A-14Reaffirmed: CSAPH Rep. 04, A-19Reaffirmation: I-19

#### **Global Climate Change – The “Greenhouse Effect” H-135.977**

- Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting; (2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production; (3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity; (4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and (5) encourages humanitarian measures to limit the burgeoning increase in world population.

Citation: CSA Rep. E, A-89Reaffirmed: Sunset Report, A-00Reaffirmed: CSAPH Rep. 1, A-10Reaffirmation A-12Reaffirmed in lieu of Res. 408, A-14

#### **AMA Advocacy for Environmental Sustainability and Climate H-135.923**

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

Citation: Res. 924, I-16Reaffirmation: I-19

#### **Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership D-135.968**

Our AMA will continue to explore environmentally sustainable practices for *JAMA* distribution.

Citation: BOT Rep. 8, I-19

**AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969**

Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels.

Citation: BOT Rep. 34, A-18

**Stewardship of the Environment H-135.973**

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation. (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89 Amended: CLRPD Rep. D, I-92 Amended: CSA Rep. 8, A-03 Reaffirmed in lieu of Res. 417, A-04 Reaffirmed in lieu of Res. 402, A-10 Reaffirmation I-16

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 16  
(A-21)

Introduced by: Anna Yap, MD; Dan Pfeifle, MD; Daniel Udrea, MD; Karen Dionesotes, MD

Subject: Accountable Organizations to Resident and Fellow Trainees

Referred to: Reference Committee

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1 Whereas, The stated mission of the Accreditation Council for Graduate Medical Education  
2 (ACGME) is to, “improve healthcare and population health by assessing and advancing the  
3 quality of resident physicians’ education through accreditation”<sup>1</sup>; and  
4

5 Whereas, To achieve its mission the ACGME has determined that it has two main purposes:  
6 “(1) to establish and maintain accreditation standards that promote the educational quality of  
7 residency and subspecialty training programs; and (2) to promote conduct of the residency  
8 educational mission with sensitivity to the safety of care rendered to patients and in a humane  
9 environment that fosters the welfare, learning, and professionalism of residents,”<sup>1</sup>; and  
10

11 Whereas, While the ACGME has taken steps to advocate for residents, its ability to effectively  
12 and timely work on their behalf is limited by “blunt tools” related to removal of accreditation and  
13 delay in providing feedback to programs<sup>3</sup>; and  
14

15 Whereas, our AMA Residents and Fellows’ Bill of Rights (H-310.912) establishes that residents  
16 and fellows have rights to: (1) have a safe workspace that enables them to fulfill their clinical  
17 duties and educational obligations; (2) defend themselves against any allegations presented by  
18 a patient, health professional, or training program in accordance with due process guidelines  
19 established by the AMA; (3) be able to file a formal complaint with the ACGME to address  
20 program violations of residency training requirements without fear of recrimination and with the  
21 guarantee of due process; and (4) confidentially evaluate faculty and programs and expect that  
22 the training program will address deficiencies by these evaluations in a timely fashion<sup>4</sup>; and  
23

24 Whereas, Resident and fellow trainees still endure suboptimal training conditions, with recourse  
25 to address these issues limited by multiple factors including a high debt burden and fear of their  
26 program losing accreditation thus affecting future career prospects, which ultimately makes  
27 reporting even gross ACGME guideline infractions difficult to encourage<sup>5,6</sup>; and  
28

29 Whereas, During the COVID-19 pandemic, residents and fellow trainees have been particularly  
30 susceptible to poor conditions including limited availability of personal protective equipment  
31 (PPE), longer work hours, lack of hazard pay or similar programs, redeployment into other  
32 specialties which may or may not be relevant to education in their own specialty, and difficulty in  
33 securing workers’ compensation in the event of severe illness, with many programs revoking  
34 promised stipend increases<sup>6</sup>; and  
35

36 Whereas, The rate of closure of family medicine residency programs is increasing, and the  
37 Federation of State Medical Boards (FSMB) has records of over 50 hospitals with accredited  
38 training programs that have closed, with indications that more closures can be expected across  
39 the country in multiple specialties<sup>7,8</sup>; and

1 Whereas, As exemplified by the Hahnemann University Hospital closure, residents and fellow  
2 trainees are vulnerable to the negative effects of hospital closures that threaten the quality and  
3 completion of their graduate medical education, financial wellbeing, and legal status within the  
4 United States,<sup>9,10</sup>; and  
5

6 Whereas, Numerous organizations such as the ACGME, AMA, American Osteopathic  
7 Association (AOA), American Board of Medical Specialties (ABMS), Association of American  
8 Medical Colleges (AAMC), Council of Medical Specialty Societies, National Board of Medical  
9 Examiners (NBME), Pennsylvania Medical Society (PAMED), Philadelphia County Medical  
10 Society (PCMS), and Educational Commission for Foreign Medical Graduates (ECFMG)  
11 responded to the Hahnemann closure as well as other residency closures with offers of legal  
12 assistance, grants, visa assistance, tail-insurance coverage, and other forms of support<sup>11</sup>; and  
13

14 Whereas, The majority of funding for Graduate Medical Education (GME) is through Medicare  
15 and Medicaid, with additional funding through the U.S. Department of Veteran Affairs (VA) and  
16 Health Resources and Services Administration (HRSA), as well as private hospital funding<sup>12</sup>;  
17 and  
18

19 Whereas, The Centers for Medicare & Medicaid Services (CMS) is tasked with distributing the  
20 majority of GME funding, but is not responsible for overseeing the quality of training programs  
21 nor the wellness or treatment of trainees<sup>12</sup>; and  
22

23 Whereas, None of the organizations that responded to the Hahnemann residency closures were  
24 required to by law, nor was the response coordinated, regulated, or monitored by any type of  
25 oversight organization with regards to resident and fellow interests, and an ACGME  
26 investigation of the closure of the Hahnemann University Hospital found that no existing  
27 organizations represented resident and fellow interests to the exclusion of other stakeholder  
28 interests.<sup>3,11</sup>; therefore be it  
29

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

Fiscal Note:

**References:**

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**Relevant RFS Position Statements:**

**Relevant AMA Policy:**

**Residents and Fellows' Bill of Rights H-310.912**

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

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

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

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. 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.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

Citation: CME Rep. 8, A-11Appended: Res. 303, A-14Reaffirmed: Res. 915, I-15Appended: CME Rep. 04, A-16Modified: CME Rep. 06, I-18Appended: Res. 324, A-19

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 17  
(A-21)

Introduced by: Elizabeth Southworth, MD; Laura Stone McGuire, MD; James Docherty, DO  
Subject: Residency Program Social Media Presence to Increase Information Available to Applicants  
Referred to: Reference Committee

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- 1 Whereas, The residency application process is protracted, expensive, and often lacks  
2 transparency;<sup>1</sup> and  
3  
4 Whereas, An increasing number of applicants and increased competitiveness of the Match  
5 leads students to apply to more programs<sup>2</sup>; and  
6  
7 Whereas, Through AMA's Reimagining Residency initiative, the Association of Professors of  
8 Gynecology and Obstetrics created specialty-wide standards for the Ob-Gyn Residency  
9 Application and Interview Processes such as allowing applicants a minimum of 72 hours after  
10 an interview invitation email to respond<sup>3</sup>; and  
11  
12 Whereas, 17% of one survey's respondents stated they used social media to evaluate GME  
13 programs and 28% of social-media using respondents used social-media not generated by the  
14 program itself (i.e., student doctor network)<sup>4</sup>; and  
15  
16 Whereas, In the above study, 85% of respondents reported their desired program did not have a  
17 social media presence<sup>4</sup>; and  
18  
19 Whereas, A radiology program director survey showed 45% of institutions block social media  
20 websites on their network, creating difficulties in managing profiles while at the institution<sup>5</sup>; and  
21  
22 Whereas, Our MSS has passed policy to recognize the need for improved communication  
23 between programs and applicants (310.019 MSS); and  
24  
25 Whereas, Our AMA has passed policy to improve the residency application process for  
26 applicants (H-310.998); therefore be it  
27  
28 RESOLVED, That our AMA study existing communication practices during the residency  
29 application process; and be it further  
30  
31 RESOLVED, That our AMA develop best practices for the use of social media by residency  
32 programs; and be it further  
33  
34 RESOLVED, That our AMA support residency programs' social media presence as a means to  
35 share updated information with applicants.

Fiscal Note:

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#### **Relevant RFS Position Statements:**

##### **260.016R Providing Residency Applicants a Timely Response to Residency Application Outcome:**

That our AMA amend HOD policy H-310.998 Residency Interview Schedules to read: H-310.998 Residency Interview Schedules The AMA encourages residency and fellowship programs to incorporate in interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. The AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. The AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of their application materials and timely notification of when an applicant is no longer under consideration for an interview. (Resolution 1, I-13) [HOD Resolution 302, A-14]

#### **Relevant AMA Policy:**

##### **Residency Interview Schedules H-310.998**

1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.

2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

Citation: Res. 93, I-79Reaffirmed: CLRPD Rep. B, I-89Appended: Res. 302 and Res. 313, I-97Reaffirmed: CME Rep. 2, A-07Modified: Res. 302, A-14Appended: Res. 314, A-19

##### **National Resident Matching Program Reform D-310.977**

Our AMA:

(1) will work with the National Resident Matching Program to develop and distribute educational programs to better inform applicants about the NRMP matching process;

(2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;

(3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;

(4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises;

(5) will work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;

- (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
- (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
- (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicant;
- (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
- (10) will work with the National Resident Matching Program (NRMP) and Accreditation Council for Graduate Medical Education (ACGME) to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
- (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
- (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
- (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
- (14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
- (15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
- (16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies; and
- (17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine.

Citation: CME Rep. 4, A-05Appended: Res. 330, A-11Appended: Res. 920, I-11Appended: Res. 311, A-14Appended: Res. 312, A-14Appended: Res. 304, A-15Appended: CME Rep. 03, A-16Reaffirmation: A-16Appended: CME Rep. 06, A-17Appended: Res. 306, A-17Modified: Speakers Rep. 01, A-17

#### **Policy Suggestions to Improve the National Resident Matching Program D-310.974**

Our AMA will: (1) request that the National Resident Matching Program review the basis for the extra charge for including over 15 programs on a primary rank order list and consider modifying the fee structure to minimize such charges; (2) work with the NRMP to increase awareness among applicants of the existing NRMP waiver and violations review policies to assure their most effective implementation; (3) request that the NRMP continue to explore measures to maximize the availability of information for unmatched applicants and unfilled programs including the feasibility of creating a dynamic list of unmatched applicants; (4) ask the National Resident Matching Program (NRMP) to publish data regarding waivers and violations with subsequent consequences for both programs and applicants while

maintaining the integrity of the match and protecting the identities of both programs and participants; (5) advocate that the words "residency training" in section 8.2.10 of the NRMP Match agreement be added to the second sentence so that it reads, "The applicant also may be barred from accepting or starting a position in any residency training program sponsored by a match-participating institution that would commence training within one year from the date of issuance of the Final Report" and specifically state that NRMP cannot prevent an applicant from maintaining his or her education through rotating, researching, teaching, or otherwise working in positions other than resident training at NRMP affiliated programs; and (6) work with the Educational Commission for Foreign Medical Graduates, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, and other graduate medical education stakeholders to encourage the NRMP to make the conditions of the Match agreement more transparent while assuring the confidentiality of the match and to use a thorough process in declaring that a violation has occurred.

Citation: CME Rep. 15, A-06Appended: Res. 918, I-11Appended: CME Rep. 12, A-12