AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Informational Report: A
(A-24)

Introduced by: RFS Governing Council

Subject: Guidance for Sectional Delegate and Sectional Alternate Delegate Vacancies

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Background

This document outlines the steps and responsibilities for addressing vacancies in the American Medical Association Resident and Fellow Section (AMA-RFS) Sectional Delegate (SD) and Sectional Alternate Delegate (AD) positions.

The AMA-RFS Internal Operating Procedures (IOPs) outline the current election procedures. In short, SDs and ADs are elected at every Interim meeting by a majority-approval system of voting-eligible RFS members. As of December 2023, the RFS is allotted 35 SDs and 35 ADs. In addition to securing a majority of votes, candidates must also secure an endorsement from their state society, specialty society, Federal Service, or professional interest medical association (PIMA) within 30 days of the election.

Per the IOPs, a runoff election between the remaining candidates can be held if there are unfilled seats after an SD election. If there are still vacancies, one additional Sectional Delegate and Alternate Delegate per endorsing group will be allowed. After SD elections, unsuccessful candidates may slate to run for AD. The above process is repeated as necessary until all seats are filled.

The IOPs give some guidance on what to do with temporary vacancies, but the guidance is limited. Per the IOPs, the RFS Delegate and Alternate Delegate may appoint a temporary delegate or alternate delegate to a vacancy for a given House of Delegates meeting at their discretion.

However, there is little guidance on what to do if there are ***permanent*** vacancies as a result of (1) SD/ADs losing eligibility to be in their position due to lapse in membership in the AMA and/or RFS; (2) insufficient candidates at the time of election; or (3) failure of candidates to secure an endorsement and therefore inability to fill their role.

Discussion

1. Identification of Vacancies
    a. The RFS Delegate and Alternate Delegate (hereby referred to as “The RFS Delegates”) shall promptly identify any Sectional Delegate and Sectional Alternate Delegate vacancies post-election.
    b. The vacancy may occur due to resignation, ineligibility, or any other reason that renders the position vacant.
    c. Vacancies may either be temporary or permanent.
        i. Temporary vacancies are for a fixed amount of time, assuming the individual will return to the delegation for the remainder of their elected term.
        ii. Permanent vacancies are for the remainder of an individual’s term and will be considered a termination from the current Sectional Delegate or Sectional Alternate Delegate role.

2. Notification
    a. The departing Sectional Delegate or Sectional Alternate Delegate is responsible for formally notifying the RFS Delegates and their endorsing society (if applicable) of their intention to vacate the position and whether it is temporary or permanent.
    b. Notification should be given as soon as it is known that the individual cannot fulfill their full duties.
    c. The RFS Delegates shall notify the relevant parties, including the affected delegation, of the vacancy if the Sectional Delegate or Sectional Alternate Delegate has not already notified them.
3. Action for Permanent Vacancies
    a. The RFS Delegates and AMA Staff shall review the election results and identify the candidate who received the next highest number of votes but did not secure a position.
    b. If no such candidate exists, the RFS Delegates shall appoint an individual, at their discretion, to fill the vacant Sectional Delegate or Sectional Alternate Delegate position. Attempts at filling vacant Sectional Delegate positions must first be made by promoting current Sectional Alternate Delegate
4. Guidance for Appointed Sectional Delegates and Alternate Delegates for Permanent Vacancies
    a. The goal of the appointment process is to have a full delegation of 35 Sectional Delegates and 35 Sectional Alternate Delegates at all times.
    b. Appointments may happen at any time during the year.
    c. The RFS Delegates shall announce the vacancies, including the timeline, eligibility criteria, and application instructions for candidates. At a minimum, announcements should entail emailing the AMA-RFS section and posting on the AMA-RFS Leadership Opportunity webpage.
    d. Interested candidates must submit their nominations within the specified timeframe. Extensions for extenuating applicant circumstances are made on a case-by-case basis.
    e. The RFS Delegates shall appoint individuals and may repeat the above process as often as needed throughout the year for a full delegation.
    f. Temporary vacancies will be handled separately, as already outlined in the RFS IOPs.
    g. If there are more candidates than vacant positions, the RFS Delegates will strive for a diverse, equitable, and inclusive appointment process. This includes but is not limited to, consideration of applicant specialty, geographic location, training year, doctorate (MD/DO), International Medical Graduate status, age, gender identity, race, ethnicity, nationality, disability, educational background, socioeconomic background, cultural background, and parental status.
5. Communication of Substitution for Permanent and Temporary Vacancies
    a. The RFS Delegates and RFS Staff shall promptly communicate the appointments to the affected endorsing societies and relevant stakeholders, including the House of Delegates office.
    b. The newly elected individual shall be introduced to the AMA-RFS membership through official channels.
6. Transition and Onboarding for Permanent and Temporary Vacancies
    a. If applicable, the outgoing and incoming Sectional Delegates and Sectional Alternate Delegates should collaborate to ensure a smooth transition, including an introduction to the endorsing society.
    b. The RFS Delegates will work with the incoming Sectional Delegate or Sectional Alternate Delegate to familiarize them with their roles, responsibilities, and ongoing

projects within the AMA-RFS. The Delegates will share the AMA-RFS Section Delegation Guide to facilitate onboarding.

7. Documentation
    a. The AMA-RFS Governing Council shall maintain accurate and up-to-date records of all communications, election results, and transition activities related to Sectional Delegate and Sectional Alternate Delegate vacancies
    b. The RFS Delegates and AMA staff are responsible for keeping an up-to-date record of the RFS Delegation.
8. Periodic Review
    a. The RFS Delegates should periodically review and, if necessary, update this guidance to reflect any changes in the election process or organizational structure.
9. Approval
    a. This guidance is subject to approval by the AMA-RFS Governing Council and may be amended with their consensus.
10. Implementation
    a. This guidance shall be implemented immediately upon approval and shall be the guiding document for addressing Sectional Delegate and Sectional Alternate Delegate vacancies within the AMA-RFS.

Recommendation

1. That our AMA-RFS file this report.

RELEVANT RFS IOPS:

G. Vacancies.

1. Sectional Delegate vacancies shall be filled by a temporary appointment from the available Sectional Alternate Delegates at the discretion of the RFS Delegate and Alternate Delegate.

2. Sectional Alternate Delegate vacancies shall be filled by a temporary appointment of RFS members present at the current House of Delegates meeting at the discretion of the RFS Delegate and Alternate Delegate.

3. Temporary appointments shall last for the duration of the House of Delegates meeting during which the appointment was made.

a) Consideration in temporary appointments shall be given to members who maintain or increase the diversity of RFS representation in the House of Delegates with regard to sponsoring state and specialty societies.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: A
(A-24)

Introduced by: RFS Governing Council

Subject: 2024-2027 RFS Policy Strategic Focus Areas

Referred to: Reference Committee

Background

The AMA-RFS is tasked with the vital and comprehensive responsibility of protecting the rights of and advancing the priorities of the residents and fellows of the United States. The AMA-RFS Governing Council acknowledges the importance of clear policy priorities and directions to advocate for these interests effectively. A thorough review of recent and historical RFS advocacy makes evident a need for more direction or consistency in issues prioritized at the AMA House of Delegates (HOD). This inconsistency, while not undermining the significance of individual resolutions, has highlighted the need for the AMA-RFS to articulate its distinct policy priorities better.

Historically, the AMA House of Delegates has addressed many issues, reflecting the diverse interests and concerns within the medical community. The AMA-RFS Governing Council recognizes that the priorities of resident and fellow physicians may differ from those of practicing physicians, necessitating a focused effort to ensure that trainees' unique challenges and opportunities are appropriately addressed. Effectively communicating RFS priorities to other groups is essential to building alliances, garnering support, and influencing policies that directly impact residents and fellow physicians.

Every year, the AMA-RFS Governing Council develops a year-long strategic plan for the Section that aligns with the AMA's Strategic Plan. In collaboration with RFS Standing Committees, prior AMA-RFS Governing Councils have also performed the task of defining an AMA-RFS Working Plan. This was most recently done in 2013, and this plan outlined a multi-year strategic plan for the Section. Though excellent in their intended effects and outcomes, these multi-year plans have often been long and complex and appear to be re-evaluated only sporadically, potentially decreasing their utility. Additionally, they do not include a focus on policymaking. Thus, the RFS Governing Council undertook the current report to describe areas of advocacy focus, intending that these areas should help guide the focus of RFS advocacy and efforts in the coming years. These strategic focus areas were developed based both on recent and historical RFS advocacy as well as consideration of the current landscape for graduate medical trainees, as described below.

It is intended that the strategic focus areas would be used in the following ways, as examples:

- Allow the RFS to clearly define to other groups what we "stand for" as a Section
- Give the RFS Section Delegates more guidance on how to prioritize our support for non-RFS resolutions at the House of Delegates
- Give guidance on potential areas of focus for RFS resolution-writers
- Give RFS Standing Committees areas to build programming around

Methods

To identify strategic focus areas, the AMA-RFS Governing Council conducted a review of

current policy as well as engaged in discussions with current and previous RFS leadership. The Governing Council solicited feedback via a survey (N=56 respondents out of approximately 200 individuals to whom it was sent) sent to current and prior AMA-RFS leaders including:

- current and immediate-past RFS Delegation
- current and immediate-past RFS Standing Committee leaders and members
- current RFS Councilors
- current and immediate-past RFS Governing Council members

The Governing Council also considered emerging trends in RFS policy priorities, challenges, and opportunities within the healthcare and graduate medical education (GME) landscapes.

Discussion

Your RFS Governing Council identified the following five strategic focus areas for the RFS (listed in no particular order):

1. Justice, Equity, Diversity, and Inclusion
2. Scope of Practice
3. Trainee Rights, Wellbeing, and Burnout
4. Medical Education
5. Healthcare Access and Coverage

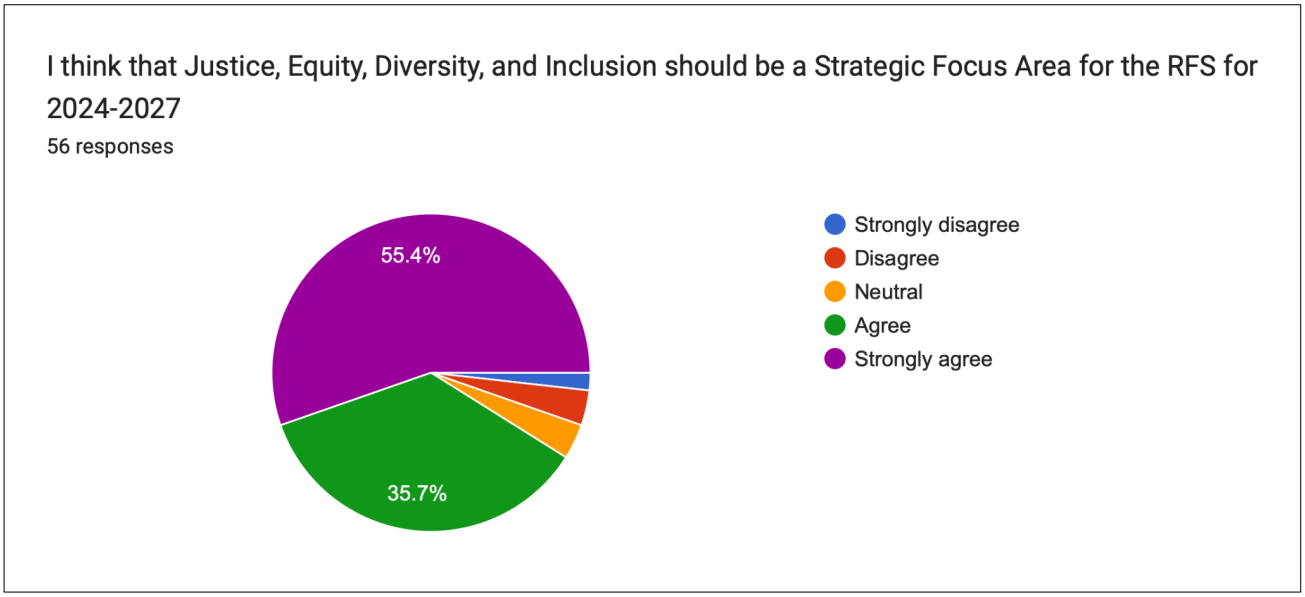
These areas are detailed below.

Justice, Equity, Diversity, and Inclusion

As future leaders in the medical profession, residents and fellow physicians are responsible for advocating for social justice and equity in healthcare. By addressing concerns related to justice, equity, diversity, and inclusion (JEDI), the AMA-RFS contributes to creating a healthcare system that is fair, accessible, and responsive to the diverse needs of all patients and healthcare workers. JEDI considerations are crucial in addressing health disparities. Focusing on justice and equity within the medical system is essential to eliminate these disparities and ensure that every patient receives high-quality, unbiased care.

Promoting diversity and inclusion within the medical profession strengthens the workforce. A diverse healthcare workforce better understands and meets the unique needs of a diverse patient population. By prioritizing JEDI concerns, the AMA-RFS contributes to building a medical community that reflects the demographics of the patients it serves and is well-equipped to recognize, address, and help eliminate bias in current medical practice.

Trainees often face challenges related to bias and discrimination. By centering justice and equity, the AMA-RFS aims to create an environment where all residents and fellow physicians are treated fairly and respectfully, and their diverse backgrounds are acknowledged and celebrated. This involves advocating for policies and initiatives that focus on preventing discrimination, promoting diversity, supporting those who face bias, and creating an atmosphere where all can reach their potential.



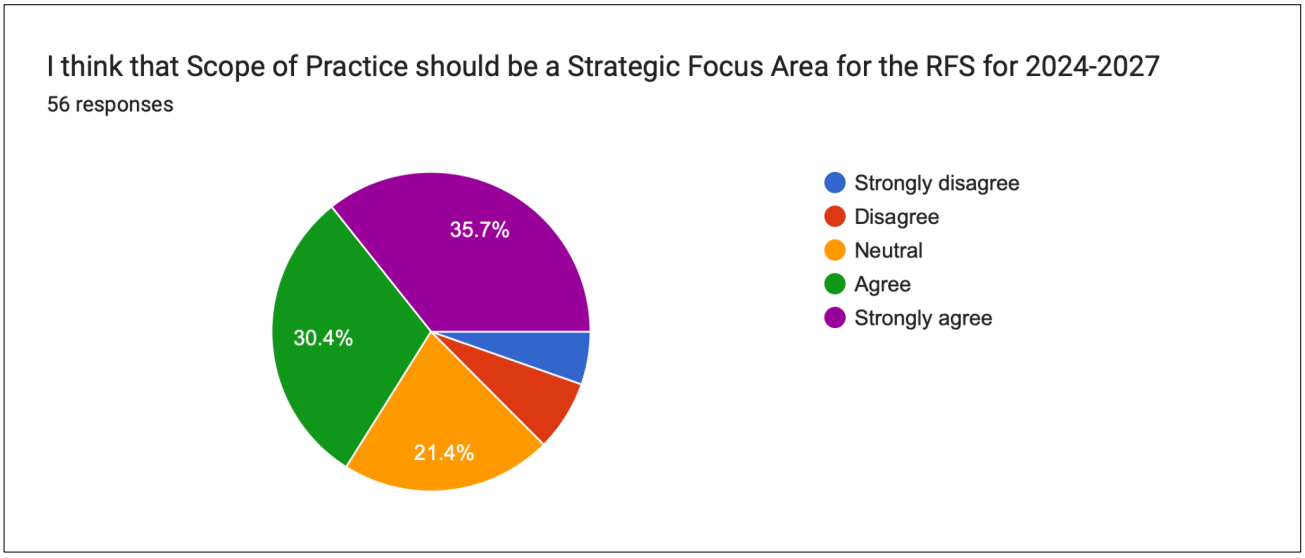
Examples of recently passed RFS policy in this SFA include:

- ***550.010R*** *Editorial Changes to Outdated and Stigmatizing Language in the RFS Digest of Actions: (Annual 2023)*
- ***550.012R*** *Updating Language Regarding Families and Pregnant Persons (Annual 2023)*
- ***560.006R*** *On the Creation of an RFS JEDI Committee (Annual 2023)*
- ***130.019R*** *Confidentiality of Sexual Orientation and Gender Identity Data (Annual 2023)*
- ***140.102R*** *Redressing the Harms of Misusing Race in Medicine (Annual 2023)*
- ***360.004R*** *Support of Elimination of the Deferment Period for Blood Donation by Men Who Have Sex with Men (MSM) (Annual 2023)*
- **350.007R** *Increasing Minority and Underrepresented Group Participation in Clinical Research (Interim 2022)*

Scope of Practice

Unmerited scope expansion can lead to situations where healthcare professionals, including nurse practitioners and physician assistants, may take on responsibilities beyond their training and expertise. Ensuring that each healthcare provider practices within their trained and licensed scope of practice is essential for maintaining high patient safety standards and delivering quality care. Physician trainees undergo extensive specialized training to develop the skills and knowledge required to provide comprehensive medical care. Expansion of scope without appropriate increased training can devalue this investment by allowing other healthcare professionals to practice in areas that necessitate physicians' extensive training. Addressing this issue protects the integrity of physician training and expertise and safeguards equity in providing all patients access to practitioners with the highest level of knowledge.

The AMA-RFS immensely values our fellow health professionals and recognizes the importance of interprofessional collaboration. It emphasizes the need for clear role delineation to ensure that each healthcare team member contributes according to their training and capabilities. Advocating for clarity in professional roles helps maintain physicians' distinct contributions to patient care, preventing the dilution of the medical profession's expertise and ensuring that patients have access to physicians at the forefront of healthcare decision-making.



Examples of recently passed RFS policy in this SFA include:

- ***380.021R*** *Preserving Physician Leadership in Patient Care (Annual 2023)*
- ***380.022R*** *Amend Policy D-275.948, "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training" (Annual 2023)*
- ***281.024R*** *Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals (Annual 2022)*
- ***40.004R*** *The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training (Annual 2022)*

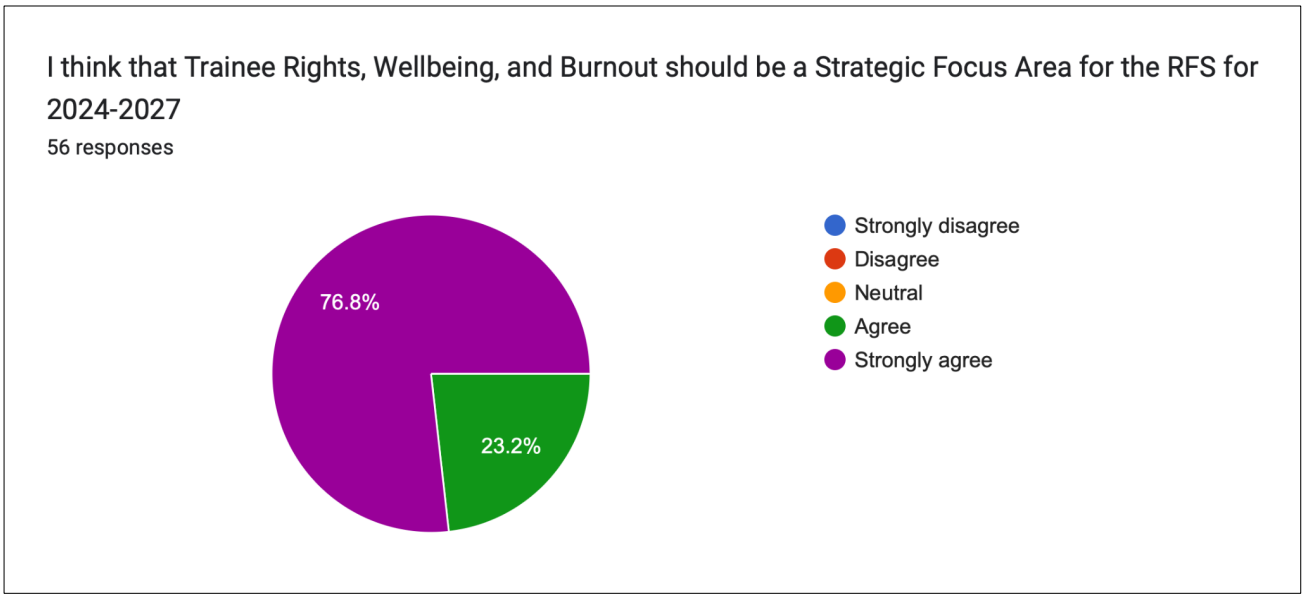
Trainee Rights, Wellbeing, and Burnout

Trainees often face unique challenges, combining long working hours, high-stress situations, and demanding responsibilities. Prioritizing trainee rights and well-being allows the AMA-RFS to advocate for fair and ethical treatment, minimizing the risk that trainees will be subjected to exploitation, mistreatment, or inhumane working conditions to protect and improve trainees' physical and mental health. Addressing trainee rights, well-being, and burnout is a direct investment in the health and resilience of the future physician workforce. Ideally, training should be a healing experience so future medical practitioners can heal others. Recognizing the incongruence of this ideal with the current status of undergraduate medical education (UME) and GME, our AMA-RFS has focused great energy and attention on improving the current system.

Burnout is highly prevalent among healthcare professionals, including trainees, and can harm personal health, job satisfaction, and patient care. Addressing burnout can help ensure residents and fellows focus on acquiring the necessary skills, knowledge, and competencies. Prioritizing well-being helps ensure trainees are in the best mental and physical condition to deliver safe, high-quality patient care.

Additionally, burnout is a significant factor contributing to the high attrition rates among healthcare professionals. Addressing well-being and burnout among trainees can help reduce the likelihood of early career departures, preserving the investment made in training and contributing to a more stable and resilient healthcare workforce.

Just as importantly, centering trainee rights, prioritizing wellbeing, and addressing burnout are vital to allowing trainees to have complete and fulfilling lives inside and outside the workday.



Examples of recently passed RFS policy in this SFA include:

- ***240.017R*** *Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being (Interim 2023)*
- ***291.038R*** *Recognizing Moral Injury in Medicine as a Phenomenon Distinct from Burnout (Interim 2023)*
- ***294.024R*** *Pregnancy and Parental Leave for Trainees (Interim 2023)*
- ***170.011R*** *Investigation into Residents, Fellows, and Physician Unions (Annual 2023)*
- ***170.012R*** *Elimination of Non-Compete Clauses in Employment Contracts (Annual 2023)*
- ***291.009R*** *Resident and Fellow Bill of Rights (Annual 2023)*
- ***294.023R*** *Residents Verification of Training and Credentials (Annual 2023)*
- ***240.015R*** *Maintenance of Certification and Maintenance of Licensure (Annual 2022)*
- ***291.006R*** *Use of Elective Time during Medical Training for Maternity Leave (Annual 2022)*
- ***291.017R*** *Resident/Fellow Work and Learning Environment (Annual 2022)*
- ***291.035R*** *Evaluating the Effect of ACGME Resident Work-Hours Reforms (Annual 2022)*
- ***292.009R*** *Due Process Grievance Procedures, and Graduate Medical Education Reform (Annual 2022)*
- ***293.011R*** *Benefit Packages for Resident Physicians (Annual 2022)*
- ***380.019R*** *Fees for NBME Scores (Annual 2022)*

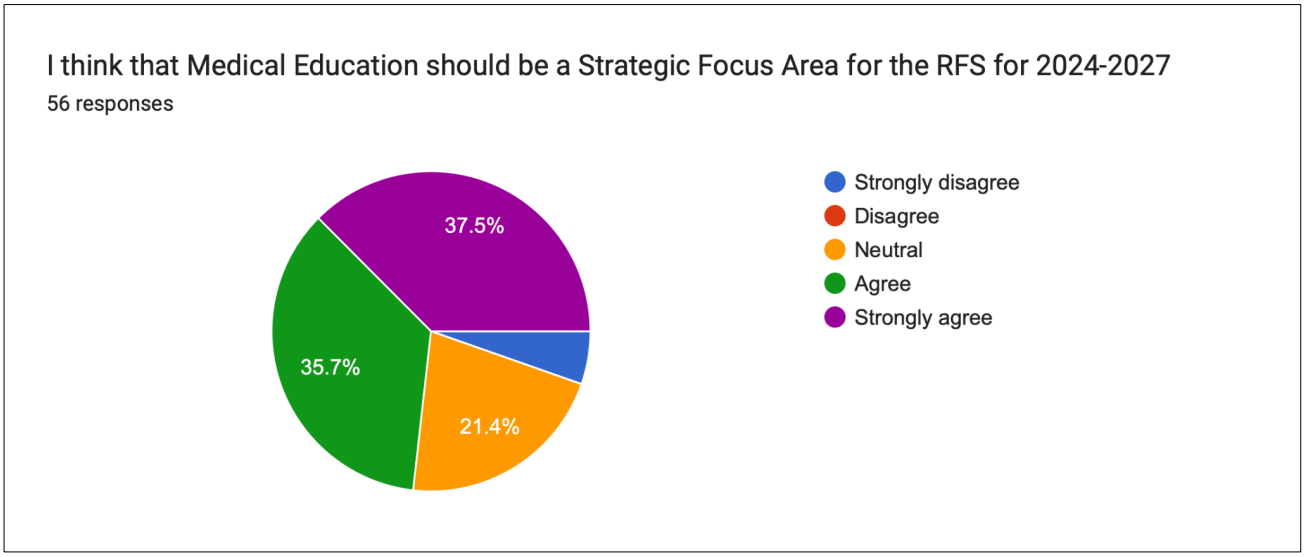
Medical Education

The foundation of providing high-quality patient care lies in the quality of medical education. By prioritizing medical education, the AMA-RFS ensures that future physicians receive comprehensive, up-to-date training. A well-rounded and rigorous education equips physicians with the knowledge, skills, and attitudes necessary for effective clinical practice and desired

patient outcomes.

Healthcare is a dynamic field with evolving challenges and opportunities. Prioritizing medical education enables the AMA-RFS to advocate for and participate in developing and adopting innovative teaching methods and curricula that keep pace with the evolving landscape of healthcare.

Medical education policies should support adequate funding, resources, and infrastructure for medical schools and residency and fellowship programs, ensuring the continuous development of a skilled and diverse healthcare workforce. The financial aspects of medical education, including student debt and funding for GME, are significant concerns for trainees. The AMA-RFS can advocate for policies addressing these economic challenges, ensuring aspiring physicians can pursue their education without facing excessive financial burdens.



<u>Examples of recently passed RFS policy in this SFA include:</u>

- ***294.025R*** *Decreasing Osteopathic Bias in Residency and Fellowship Applications (Interim 2023)*
- ***350.008R*** *Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine (Interim 2023)*
- ***260.021R*** *Medical School Management of Unmatched Medical Students (Interim 2022)*
- ***170.007R*** *Opposition to Deficit Enrollment (Annual 2022)*
- ***170.008R*** *Preservation of Residency Training Positions (Annual 2022)*
- ***220.002R*** *Restoration of J-1 Visa Waivers for Underserved Communities (Annual 2022)*
- ***260.002R*** *Health Policy Education in Medical School and Residency (Annual 2022)*
- ***260.010R*** *Clinical Skills Assessment as Part of Medical School Standards (Annual 2022)*
- ***260.020R*** *Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training (Annual 2022)*
- ***281.018R*** *Medical School Tuition (Annual 2022)*
- ***294.021R*** *Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education (Annual 2022)*
- ***295.009R*** *Improving Patient Safety Through Collaboration in Resident and Fellow*

Education (Annual 2022)

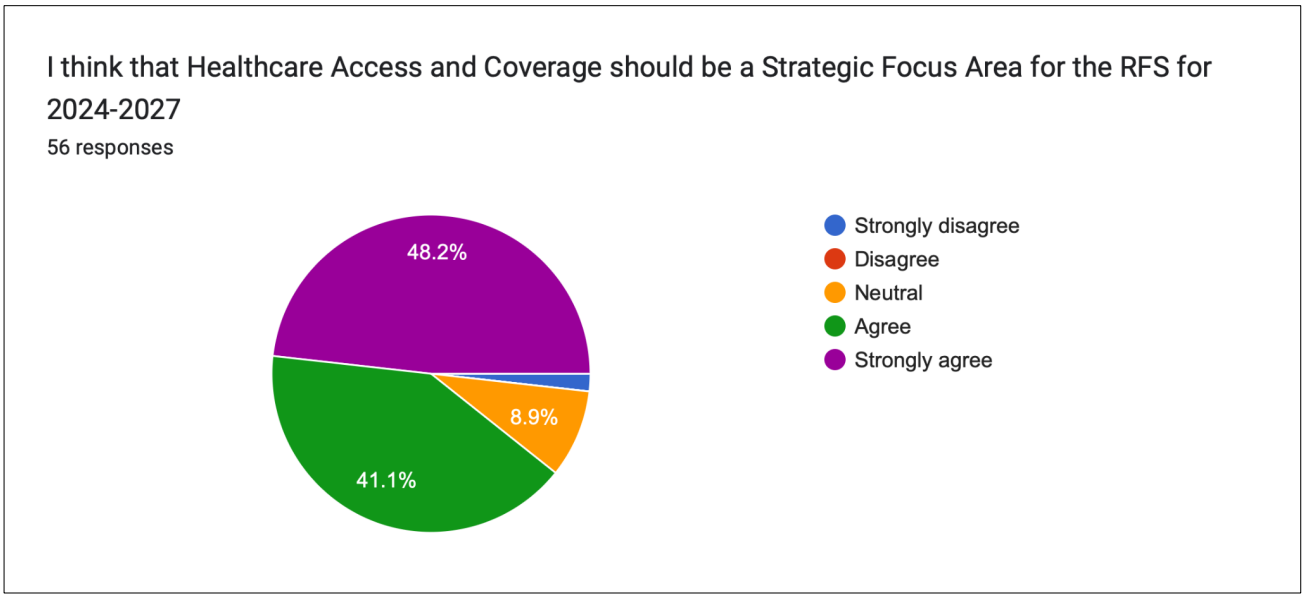
Healthcare Access and Coverage

Access to healthcare is integral to patient-centered care. The AMA-RFS is responsible for advocating for policies that promote equitable access to and coverage of healthcare services, reflecting the ethical obligation to prioritize patient well-being.

Access to and coverage of healthcare directly influence health outcomes. The AMA-RFS plays a vital role in promoting preventive care, early intervention, and management of chronic conditions, contributing to better public health and well-being. The AMA-RFS can play a pivotal role in advocating for policies that move towards achieving universal healthcare coverage. Prioritizing this issue aligns with ensuring all individuals have access to essential healthcare services regardless of their financial or social situation.

Ensuring access to healthcare services helps prevent the strain on the healthcare system. Adequate access facilitates timely and appropriate care, reducing the likelihood of delayed treatments, advanced disease states, and increased or emergency healthcare costs.

By prioritizing this topic, the AMA-RFS contributes to developing and advocating policies that enhance healthcare delivery efficiency, promoting resource allocation and utilization in a manner that benefits both patients and healthcare providers.

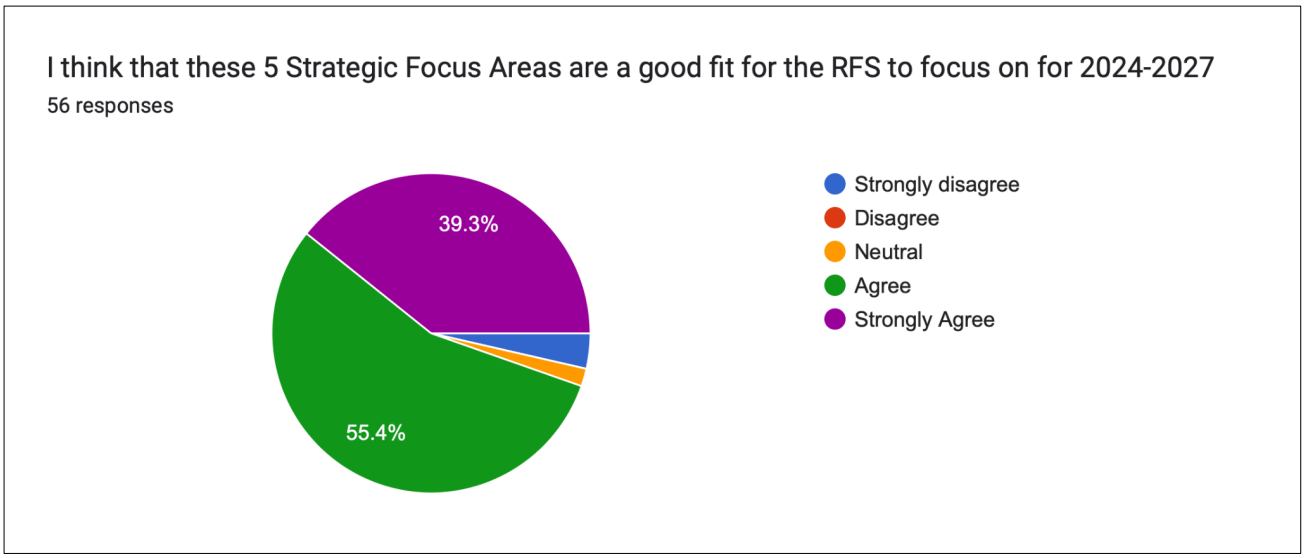


<u>Examples of recently passed RFS policy in this SFA include:</u>

- ***80.012R*** *Early and Periodic Eye Exams for Adults (Interim 2023)*
- ***140.103R*** *Amendment to AMA Policy on Healthcare System Reform Proposals (Interim 2023)*
- ***410.036R*** *Studying Avenues for Parity in Mental Health & Substance Use Coverage (Interim 2023)*
- ***410.034R*** *Decriminalizing and Destigmatizing Perinatal Substance Use Treatment (Annual 2023)*
- ***140.101R*** *Preserving Access to Reproductive Health Services (Interim 2022)*

- ***294.017R*** *Access to Medication and Procedural Abortion Training (Interim 2022)*
- ***294.022R*** *Support for GME Training in Reproductive Services (Interim 2022)*
- ***140.007R*** *AMA-RFS Participation in the AMA's Effort to Reevaluate the U.S. Health Care Delivery System (Annual 2022)*
- ***170.002R*** *National Health Service Corps (Annual 2022)*
- ***390.006R*** *Opposition to Criminalization of Reproductive Decision Making (Annual 2022)*
- ***70.002R*** *Harm Reduction Strategies for Patients at Risk of Opioid Overdose (Annual 2022)*
- ***80.010R*** *Illicit Drug Use Harm Reduction Strategies (Annual 2022)*

Overall Fit:



Recommendations:

1. The AMA-RFS establishes its strategic policy focus areas for 2024-2027: (1) justice, equity, diversity, and inclusion; (2) appropriate scope of practice; (3) trainee rights, well-being, and burnout; (4) medical education; and (5) healthcare access and coverage.
2. The AMA-RFS Governing Council will periodically return to and revise, as necessary, the strategic focus areas to align with current Section needs and priorities.
3. The AMA-RFS encourages the development of robust internal policies within these focus areas.
4. The AMA-RFS Caucus to the AMA House of Delegates (HOD) will consider more highly prioritizing items falling within these strategic focus areas.
5. The AMA-RFS Delegation to the AMA HOD will continue to highly prioritize any RFS-authored resolution submitted to the HOD, regardless of whether or not it falls into one of these strategic focus areas.

In conclusion, the AMA-RFS Governing Council is committed to advancing these policy strategic focus areas to enhance resident and fellow physicians' professional experience, well-being, and advocacy capabilities.

RELEVANT RFS POLICY:

550.003R AMA-RFS Strategic Plan: Vision, Mission, and Objectives

That our AMA-RFS utilize the vision, mission and objectives set forth by the AMA-RFS Committee on Long Range Planning as a foundation for further planning. (Report E, A-01) (Reaffirmed Report D, I-16)

550.008R 2013-2016 Working Plan
Asked that:
In the realm of National Meetings: (1) The RFS Governing Council should work with the AMA to encourage RFS participation between meetings and that: a) the RFS should continue to work to ensure that the MSS/RFS research poster symposia continues to be held at a national meeting, b) the RFS Governing Council will continue to work with staff to increase resident and fellow attendance at leadership training events, including the National Advocacy Conference and AMA leadership retreats; (2) The RFS Governing Council should continue to improve the process of election procedures to ensure adequacy, transparency and integrity of the results; (3) The RFS Governing Council should continue to work to improve content at national meetings that will be relevant to members and that will engage them in the core areas of AMA involvement, Advocacy, Public Health, Community Service, Legislative Policy, Leadership Development and Membership.

In the realm of Advocacy: (4) The RFS should continue to make preserving and improving GME funding and addressing future physician workforce issues a key priority of our advocacy actions; (5) The RFS Governing Council should continue to annually identify key issues and mobilize the grassroots network to involve our section in advocating for RFS friendly positions on said issues and continue to educate the general assembly on these issues; (6) That the RFS should continue to work with other resident and fellow based organizations to ensure that the RFS serve as the national spokesperson for all resident and fellow centered issues including student debt, graduate medical education, medical licensure, and resident work hours.

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

In the realm of Communication: (13) The RFS and RVS Governing Council should work to establish online social media portals to encourage involvement in RFS activities and increase RFS awareness; (14) The RFS Governing Council should investigate methods to ensure there is effective communication with the region leadership on a regular basis; (15) the RFS Governing Council should establish a mechanism to provide Governing Council updates and direct communication to our membership and work with AMA staff to ensure that these updates be disseminated to all RFS members; and (16) The RFS Governing Council should actively work to increase utilization of the RFS listserv and make it available to new members.

In general, the Committee recommends that: (17) the RFS recommend that a Working Plan be developed by the Committee on Long Range Planning for the RFS Governing Council and approved by the

assembly at least every 3 years. (Late Report H, I-13)

580.002R AMA-RFS Strategic Plan

The following strategic plan for AMA- RFS was adopted for 2010-2011:
In the realm of Membership:
1. The RFS should work with the MSS, membership staff, YPS, and County and State medical societies, to develop longitudinal membership drive initiatives that encompass all aspects of physician training from medical school graduation to completion of residency and fellowship training;
2. The AMA-RFS should ensure that there is an RFS-GC member and staff member who is in regular contact with the AMA membership staff and who will serve in an advisory role to the membership department in regards to the creation and implementation of RFS membership initiatives;
3. The AMA-RFS should work with the AMA membership staff to research and develop new membership incentives tailored to prospective RFS members

In the realm of Advocacy:
4. The RFS will work with staff and local medical societies to secure additional funding and resources to increase resident activism at the National Advocacy Conference and Lobby Day;
5. The RFS continue to schedule RFS national lobby day concurrently with State and Specialty societies, while at the same time maintaining a direct interaction with the MSS during MSS lobby day;

In the realm of Communication:
6. The AMA-RFS should publicize the RFS Facebook page, and utilize the Facebook page to create discussion and interaction among members;
7. The GC should appoint a member to serve as a moderator over the AMARFS website, Facebook page, and e-mail publications, who will be responsible to post information to the sites as well as moderate and/or create discussion topics;
8. The RFS Voice should be continued as a print mailing to RFS members, and the RFS should augment print mailings with an on-line newsletter over national and regional list-servs;
9. The RFS should work with the AMA to gather new and current members' email addresses and maintain a members' e-mail database;

In the realm of the RFS Regions:
10. The RFS should conduct a thorough examination of the role of the regions within the RFS including the function of the Regional Council, improved communication within the regions, and expansion of regional leadership;
11. The RFS should set the goal of planning with region leadership one to two local-regional events in centers of high concentration of physicians in training;

In General, the Committee recommends that:
12. The RFS GC report back to the RFS from time to time regarding the progress of each of these recommendations, with a first mandated report back at A-11;
13. The RFS mandate that a strategic plan should be developed for the section at least every 3 years. (Report F, A-10)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: B
(A-24)

Introduced by: RFS Governing Council

Prepared by: Ad hoc Committee on RFS Internal Operating Procedures Revisions

Subject: Modernization of the AMA Resident and Fellow Section Internal Operating Procedures

Referred to: Reference Committee

Purpose

The Ad hoc Committee on RFS Internal Operating Procedures Revisions was assembled by the Governing Council to review and modernize the AMA-RFS Internal Operating Procedures (IOPs). These recommendations are presented to the RFS Assembly for discussion and approval, with final language requiring review by the AMA Council of Constitution and Bylaws and the AMA Board of Trustees.

Background

The 2022-2023 Ad hoc Committee on RFS Internal Operating Procedures Revisions was established to update the RFS IOPs to best serve the evolving needs of the Section. Due to pending reports scheduled for transmission to the AMA House of Delegates that had the potential to impact the RFS IOPs, a report summarizing the discussions and initial recommendations of the 2022-2023 Committee on RFS Internal Operating Procedures Revisions was filed at A-23 but the Section passed no changes to the RFS IOPs at that time. The current Committee on RFS Internal Operating Procedures Revisions was therefore convened to refine further the recommendations in the 2022-2023 Committee's report.

Composition

The following Committee on RFS Internal Operating Procedures Revisions members were appointed by the Governing Council:

- Chair: Haidn Foster, MD (RFS Chair-Elect)
- Vice Chair: Lewis Wong, MD
- Membership: Victoria Gordon, DO; Danielle Gutierrez Rivera, MD; Whitney Sambhariya, MD
- GC Liaison: Dayna Issacs, MD (RFS Vice Chair)

Timeline

August—September 2022	Committee members completed an independent review of assigned sections and submitted draft language.
November 2022	First progress report uploaded to the Virtual Reference Committee (VRC) for member commentary.
December—	The Governing Council convened to review and discuss proposed language.

January 2022	The Committee is asked to evaluate the issue of leadership opportunities within the RFS.
February 2023	Committee members convened to discuss the issue of leadership within the RFS and to review feedback from the Governing Council. The second progress report was adapted accordingly.
March 2023	The second redlined IOP progress report is uploaded for RFS member comment during an open period. Following this comment period, Committee members and the resident member of the CC&B convened to review feedback and discuss further changes to the IOP report.
May – June 2023	The 2023 version of the IOP report is uploaded on the VRC and later filed with the RFS.
August 2023— February 2024	The 2023-2024 Committee on RFS Internal Operating Procedures Revisions was empaneled. Committee members completed an independent review of assigned sections and submitted draft language
September —November 2023	The 2023 IOP report was resubmitted at I-23 for comment by RFS membership and filed as information.
January 2024	A virtual town hall was held with RFS members to solicit additional feedback on the IOP report and IOP. RFS staff provided feedback regarding proposed IOP changes. The Governing Council and CC&B Councilor met with the IOP Committee chair to discuss updates to filling Sectional Delegate and Sectional Alternate Delegate vacancies.
April 2024	RFS staff provided feedback regarding proposed IOP changes. The 2024 version of the IOP report is uploaded on the VRC.

Core Areas of Discussion

Your Committee convened in between asynchronous working sessions to review and discuss any pertinent issues that were thought to be related to our IOPs, including the following. (For simplicity, references to "your Committee" shall encompass the 2022-2023 and 2023-2024 Committees on RFS Internal Operating Procedures Revisions.)

Gender Neutral Language

You Committee appreciated that an initial editorial update was made to the RFS IOPs in September 2023 to replace most instances of gendered language such as "he or she" with the gender-neutral "they." Your Committee reviewed the most recent version of the IOPs and completed the update of all such instances.

Mission of the RFS

Your Committee reviewed and reorganized the Section's mission (II.B) to center our members' values, experience with, and representation by the AMA, and role as mentors and mentees within the organization. Per staff feedback, the RFS mission of promoting the AMA Code of Medical Ethics was limited to residents and fellows, as it was felt to be infeasible to promote the Code to the broader graduate medical education community.

RFS Membership

Your Committee reviewed various issues pertaining to Section membership (III.A).

First, your Committee received requests to provide clarification within the IOPs addressing the ambiguities in AMA Bylaw 7.1.1, including the absence of a definition for "primary occupation" as a resident or fellow that would define membership eligibility in the RFS. In a discussion with a past resident member on CC&B, the Committee confirmed that any changes to membership eligibility would require a change to the AMA Bylaws, as membership is already defined by Bylaw 7.1.1; that is, revisions to the RFS IOPs to provide any such clarification would not supersede the bylaws as written. Your Committee discussed the merits of proposing a Bylaws Change; however, this was ultimately not pursued as a recommendation due to limited information on the sentiment of the broader membership and concern for unintended consequences once this section of the bylaws becomes subject to House debate. Thus, your Committee did not propose any additional changes to Section III.A.

Related to the issue of membership eligibility, your Committee also considered the scenario of a member who graduates from the RFS and enters the YPS before returning for additional training (e.g., an additional residency and/or fellowship). Upon further review of Bylaws 7.1.1 and 7.5.1 and in consultation with pertinent parties, including CC&B and our AMA Membership division, your Committee confirms that such members may rejoin the RFS with full rights and opportunities associated with membership. Membership between RFS and YPS is mutually exclusive. As mentioned above, given that the AMA Bylaws define this eligibility, your Committee did not feel that revisions to the IOPs were necessary.

RFS Structure

Your Committee reviewed the Section's structure, including its various committees (IX.J and XI), Regions (XII), and representation of organizations within RFS Business Meetings (IX.D).

Removing Standing Committee Enumeration. Your Committee recommends revising XI.A and XI.E to remove language enumerating specific Standing Committees of the RFS, instead describing the general role and duties of Standing Committees. This recommendation aims to allow for flexibility in the creation and modification of existing Standing Committees as appropriate to best suit the interests of the Section. This recommendation initially received mixed feedback on the 2022 open forum, with some parties approving the additional flexibility, while others cited some concern regarding loss of institutional memory. However, your Committee notes, and your 2022-2023 Governing Council confirmed, that Standing Committee descriptions are shared on the AMA-RFS webpage, on leadership applications sent semi-annually, and are passed down within the membership. Furthermore, removing specific Committee descriptions from the IOPs, this eliminates the need for regular IOP changes with ongoing creation or modification of Standing Committees such as the recent creation of the RFS Committee on Justice, Equity, Diversity, and Inclusion (JEDI). Despite mixed feedback on the 2022 open forum, this proposed change was later reviewed positively on the I-23 open forum and during the 2024 Committee town hall.

Streamlining Convention Committees. To maximize the flexibility of Convention Committee

composition, your Committee recommends removing reference to the requirement of a specific number of members within each Convention Committee (IX.J)—except for requiring an odd number of members for the Rules and Reference committees for tie-breaking purposes. These changes also acknowledge the fluctuating meeting-to-meeting requirements of the Section as well as interest in Convention Committee participation. As a Hospitality Committee has not recently been empaneled and is judged not to be vital to the execution of an RFS Business Meeting, your Committee recommends removing reference to this committee while preserving language that empowers the Governing Council to impanel ad hoc Convention Committees as it deems appropriate.

Eliminating RFS Regions. Your Committee recommends the deletion of V.G.4 and the entirety of Section XII, as the Regions leadership system has not been employed within the RFS since 2020 due to the COVID-19 pandemic. Moreover, in consultation with the 2022-2023 RFS Governing Council, the Committee learned that even before the COVID-19 pandemic, regional meetings and events were scarce, and elected regional leaders served primarily as liaisons between the Governing Council and its membership. Furthermore, even with the resumption of RFS Business Meetings, there has not been a need or vocalized desire to bring back Regional Caucuses, thereby supporting the notion that the system has been obsolete and can be removed from the IOPs.

RFS Business Meeting Representation. Your Committee noted that IX.D.2 specifies external organizations seeking representation at the RFS Business Meeting are subject to review by the Governing Council and AMA Board of Trustees, and that this same process applies to organizations at risk for discontinuation of representation. To accrue more decision-making authority to the RFS Assembly about its composition, your Committee recommends amending this process to an initial review by the Governing Council with a subsequent vote by the RFS Assembly.

Your Committee additionally recommends changing IX.D.2 to allow the involvement of national organizations consisting *primarily* of residents and fellows rather than *solely* of residents and fellows and to shorten the probationary period for new member organizations to vote in RFS elections from two years to one Business Meeting.

Late Credentialing. Intending to allow as much representation of resident/fellow voices in the RFS Business Meeting as is reasonably possible, your Committee recommends modifying IX.E to be less stringent regarding the conditions under which late credentialing for the Business Meeting will be permitted, subject to the discretion of the presiding officer and other relevant parties.

<u>RFS Leadership and Sectional Delegates</u>

Your Committee reviewed several issues related to Section leadership and representation in the AMA House of Delegates.

Eligibility for RFS Leadership Positions. Your Committee discussed eligibility for RFS leadership opportunities, as requested by various RFS members and the prior Governing Council. Currently, any resident or fellow, defined by AMA Bylaw 7.1.1 with their residency or fellowship being their “primary occupation,” is eligible to serve within RFS leadership or RFS-designated positions. In recent years, it has been suggested to use additional leadership “caps” to ensure more equitable opportunity among the membership. Your Committee agreed that such caps would be arbitrary and unnecessary outside of the term limits already delineated in the IOPs, especially as these additional caps would inadvertently penalize members who did not get

involved in the RFS until later in their training or would not qualify for leadership opportunities elsewhere outside of the RFS. Furthermore, your Committee believes that the RFS Assembly and membership should be able to self-regulate when deciding between diversity and experience in leadership. Given its tie-in with the membership issue as noted elsewhere in this report, your Committee recommends against any changes to the current eligibility criteria for RFS leadership positions.

Governing Council Duties. Your Committee recommends several updates to the duties of Governing Council members (IV.E). First, language was proposed making explicit the rise of the individuals holding the position of Vice Chair (or Chair-elect) and Vice Speaker to Chair and Speaker, respectively, should the latter positions become vacant. As the RFS no longer hosts an RFS Research Symposium, coordinating that event was removed from the responsibilities of Vice Speaker (IV.E.6). To provide additional guidance for the position of Member At-Large, further language specifying the position's role in facilitating the membership transition from MSS to RFS and RFS to YPS was added (IV.E.7)

Tenure on the RFS Governing Council. Your Committee recommends streamlining IV.F while maintaining a total term limit of four years' service on the Governing Council and two terms' service in any one role (except for Chair).

Vacancies and Substitutions among the Sectional Delegates. Your Committee received feedback during the 2022 open comment period to review the process for substitutions and vacancies among the Sectional Delegates and Sectional Alternate Delegates (VIII.G). Specifically, there was concern regarding the vacancies caused by elected members who fail to complete their entire term, often due to members graduating and ceasing to meet the Section's membership requirements. This concern was reiterated by your current Governing Council, with the additional concern that electing enough members at the Interim Business Meeting to fill all Sectional Delegate and Sectional Alternate Delegate positions has been challenging for at least the past several years. Both issues have led to vacant positions within the RFS delegation to the AMA House of Delegates that the RFS Delegates have temporarily filled from meeting to meeting—a process that is not only taxing on the RFS Delegates but one that does not ensure consistent representation of the RFS in the AMA House of Delegates throughout the year.

As a result of these concerns, your Committee, members of the Governing Council, and the resident member of CC&B met to discuss possible solutions. The most preferred solution was to modify VIII.G to remove the "temporary" qualifier from the appointment of Sectional Delegates and Sectional Alternate Delegates when vacancies arise, and to specify that the Governing Council shall establish the process by which these positions are to be filled. To this end, the Governing Council is introducing a report outlining this procedure at the current Business Meeting.

Resident/Fellow Trustee Vacancy. Your Committee received a request to modify VI.D due to concern regarding the lack of resident and fellow representation on the Board of Trustees should this position become vacant. After consulting your resident member on CC&B, the Committee confirms that this issue cannot be addressed through an IOP revision. This is because the RFS may endorse the candidate for Resident/Fellow Physician Trustee, but the Trustee is ultimately elected by the House of Delegates per Bylaw 3.4.2.2. Thus, any proposals to change this IOP would necessitate a change to Bylaw 3.5.5; given limited feedback from the broader RFS membership on this proposal, your Committee recommends referring to the relevant AMA Bylaw in our IOPs with no further modifications.

RFS Elections and Endorsements

Your Committee made significant modifications to RFS election practices (V), including broadly defining campaign periods, disallowing physical campaign materials, outlining a process by which campaign infractions are to be handled, and changing the method of electing Section leadership to a ranked-choice voting system.

Electronic Voting. Modifications were made throughout V to reflect the current practice of electronic balloting used in the RFS.

Campaign Periods. To avoid the possibility of egregiously long campaign cycles, your Committee recommends defining a campaign period (V.A.3) that exists, at a maximum, the span of the Business Meeting at which candidates are elected/endorsed and the immediate prior Business Meeting. The Governing Council would retain its authority to define a campaign period within this timeframe further.

Disallowing Physical Campaign Materials. Your Committee recommends completely barring the use of physical campaign materials in RFS elections (V.D.1) to promote greater equity between candidates and reduce or eliminate any monetary costs associated with mounting a campaign for RFS leadership positions.

Courteous and Equitable Campaigning. Your Committee recommends several changes to V.D.1.c and V.D.1.d to reduce the amount of extraneous campaign-related communications and to ensure any opportunities to address RFS members by candidates for RFS leadership are offered equitably to all candidates.

Campaign Infractions. Recognizing that no RFS policy exists regarding the handling of potential campaign rules violations, your Committee recommends the addition of new language outlining such a process (V.D.2). Your Committee used as its template the recently approved language from the MSS IOPs regarding the handling of campaign infractions. This new section of the RFS IOPs describes the primary investigators for alleged infractions, rebuttal and appeals processes, and the possibility for candidate disqualification should a candidate exceed three substantiated infractions.

Ranked Choice Voting. Your Committee recommends changing the method of electing Section leadership and endorsing candidates for AMA leadership (V.G) to a ranked-choice voting system to capture the true preferences of RFS members better and eliminate the need for runoff elections. RFS staff highlighted the failure of a previous YPS-introduced resolution calling for the implementation of ranked-choice voting within the AMA House of Delegates, but the Online Forum testimony in opposition to this change—regarding the potential for winning candidates to come primarily from large regional caucuses—was felt not to be to the RFS. In consultation with RFS staff, your Committee has been assured that a ranked-choice voting system is technologically feasible.

Two exceptions to the ranked-choice voting system were made. First, the positions of Vice Speaker and Alternate Delegate are recommended to remain separate races held after the election of other Governing Council members. This is to facilitate candidates running primarily for Vice Speaker or Alternate Delegate, as well as to allow the Assembly to allocate their votes for these “paired” positions with prior knowledge of who will serve as Speaker and Delegate. Second, the method of electing Sectional Delegates and Sectional Alternate Delegates is recommended to remain the same, given the diminishing return of attempting to simultaneously rank several dozen candidates, many of whom are likely to be new to the Section.

RFS Policy and Resolutions

Your Committee updated the RFS resolution process (IX.H). Major updates include lowering the bar to consider emergency resolutions to a two-thrids (from three-fourths) vote and reducing the time to review RFS policy through the sunset mechanism to five (from ten) years. These changes were made to increase the dynamic nature of the RFS policymaking process and ensure policy best reflects the Section's goals and ideals.

Conclusion

Your Committee would like to thank the members of the 2022-2023 Committee on RFS Internal Operating Procedures Revisions members and all members of the RFS who provided feedback on the Committees' A-23 and I-23 reports. This concludes the summary of the major Committee discussions.

Recommendation

1. That the AMA-RFS amend the RFS Internal Operating Procedures as outlined in Part II of this Report.

Part II

American Medical Association Resident and Fellow Section

Internal Operating Procedures[1]

I. Name

The name of this organization shall be the Resident and Fellow Section (RFS) of the American Medical Association (AMA). This is a special section for resident and fellow physician members of the AMA as set forth in the AMA Bylaws Section 7.1.

II. Mission

A. Mission of the Sections. AMA Bylaws Section 7.0.1 defines the mission of the AMA Sections.

B. Mission of the RFS. The RFS provides a direct and ongoing relationship between the AMA and residents and fellows. Specifically, the RFS:

1. Ensures that residents and fellows of all backgrounds and identities are treated fairly~~, regardless of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, or age~~ and given the full opportunity to ~~receive graduate medical education within the policy-making structure of~~engage in, and be represented by, the AMA.

2. Provides a forum to discuss ~~timely and controversial~~ issues~~, identify solutions, and cultivate relationships with~~ and establish policies of importance to residents and fellows.

3. Prioritizes the development of peer and mentor relationships among residents and fellows, and between RFS members and both attending physicians and medical students.

~~1.~~4. Promotes the AMA Code of Medical Ethics among residents and fellows~~ as well as the graduate medical education community~~.

~~2. Ensures that residents and fellows are treated fairly, regardless of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, or age and given the full opportunity to receive graduate medical education within the policy-making structure of the AMA.~~

~~3. Debates issues and develops policy that influence the complex and rapidly changing graduate medical education environment.~~

~~4. Provides a forum to discuss timely and controversial issues, identify solutions, and cultivate relationships with residents and fellows.~~

[1] Approved by the Board of Trustees April 2021; editorially updated September 2023 to incorporate gender neutral language

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III. Membership

A. Membership of the RFS. Membership shall be limited to resident and fellow members of the AMA as outlined in AMA Bylaws Section 7.1.1.

IV. Governing Council

A. Composition. The officers of the RFS shall be the eight elected members of the Governing Council: Chair, Vice Chair, Delegate, Alternate Delegate, Speaker, Vice Speaker, Member ~~a~~At-Large, and Chair-~~elect~~Elect or Immediate-Past Chair. ~~The Chair-Elect shall be a non-voting member and, upon completion of his or her term as Chair, shall serve as the Immediate Past Chair, an ex officio, non-voting member.~~

B. Authority. The Governing Council shall direct the programs and activities of the RFS. During the interval between meetings of the AMA House of Delegates and the RFS, the Governing Council shall act on behalf of the RFS in formulating decisions related to the development, administration, and implementation of RFS activities, programs, goals, and objectives. The Governing Council shall be guided in its work by positions passed ~~during the Business Meeting~~by the members of the RFS. The RFS shall be notified at least quarterly of actions taken by the Governing Council on its behalf.

C. Eligibility. Eligibility to serve on the Governing Council as voting members shall be limited to members in the RFS, as defined in Section III.

D. Election. All elections ~~will~~ shall be conducted in accordance with Section V.~~I~~G.1.

E. Duties. The Governing Council shall direct the programs and activities of the RFS, subject to approval, when required, by the Board of Trustees or House of Delegates of the AMA. At the end of each term, each Governing Council member is required to prepare and communicate a transition plan with their successor to that position. In addition to the aforementioned, each member of the Governing Council has responsibilities specific to each position.

Time commitments. Governing Council members are expected to participate to the fullest extent possible in the activities of the Council and the Section. Governing Council members should be prepared to commit ~~up to two days each for~~to attend the RFS Business Meeting at the Annual and Interim meetings, with the exception of the Delegate and Alternate Delegate whose commitment ~~will~~ shall be ~~up to seven days~~ for the entire Annual Meeting and ~~six days for the~~ Interim Meeting, including at the AMA House of Delegates. Governing Council members should also be prepared to commit to ~~three in-person Council meetings, plus two hours per month, on average, for~~ conference calls and other meetings as required for the business of the Section.

1. **Chair.** The Chair shall:
   a) Exercise authority as the primary officer.

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b) Represent the Section both within the AMA and in relationships with external stakeholder organizations, or designate another Governing Council member to do so.
c) Collaborate to develop and implement the strategic annual plan.
d) Preside at all meetings of the Governing Council.
e) Lead Business Meetings if the Speaker and Vice Speaker positions are vacant or if both the Speaker and Vice Speaker are otherwise unable to perform this function.

2. **Vice Chair.** The Vice- Chair shall:
   a) Coordinate internal operations of the RFS standing committees and communication with RFS members representing the Section in external capacities.
   b) Preside at meetings of the Governing Council in the absence of the Chair or at the discretion of the Chair.
   c) Assist the Chair in the performance of their duties, and shall rise to the position of Chair should the position become vacant prior to the end of the Chair's term while the position of Chair-Elect is likewise vacant.

3. **Delegate.** The Delegate shall:
   a) Represent the RFS in the AMA House of Delegates.
   b) Coordinate activities of the RFS caucus in the House of Delegates.
   c) Manage the resolutions passed during the Business Meeting and forwarded to the House of Delegates.
   d) Draft a report for the Assembly consisting of all actions taken by the RFS caucus, including the outcomes of any internal votes.
   e) Educate and provide guidance to RFS members about the policy-making processes of the Section and of the HOD, and update RFS members on HOD business and activities relevant to the Section and its members.

4. **Alternate Delegate.** The Alternate Delegate shall:
   a) Assist the Delegate in the execution of their duties and shall rise to the position of Delegate should the position become vacant before the end of the ~~position's~~ Delegate's term.

5. **Speaker.** The Speaker shall:
   a) Create the agenda for the Annual and Interim Business Meetings with input from the Governing Council and RFS staff.
   b) Preside over the Business Meetings in an impartial manner and organize and conduct them in accordance with the current parliamentary procedure authority as chosen by the House of Delegates.
   c) Ensure the RFS Business Meeting functions as delineated in Section IX.
   d) Provide for oversight and enforcement of the Campaign Rules as delineated in Section V.D.

6. ~~6.~~ **Vice Speaker.** The Vice Speaker shall;

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a) Preside at Business Meetings during the absence of or at the request of the Speaker.
b) Assist the Speaker in the performance of their duties.
~~c) Coordinate the AMA-RFS Research Symposium.~~
c) Assist the Speaker in the performance of their duties, and shall rise to the position of Speaker should the position become vacant prior to the end of the Speaker's term.

~~6.~~7. **Member At-Large.** The Member At-Large shall:
a) Coordinate the membership retention and engagement activities of the RFS, including facilitating the transition of members from the MSS to RFS, to YPS.
b) Communicate involvement opportunities, AMA member benefits, and other opportunities to current or potential resident and fellow members.
c) Foster the development of RFS membership in states and specialties where none exist and encourage increased involvement in the AMA.

~~7.~~8. **Chair-Elect.** The Chair-Elect shall:
a) Assist the Governing Council in the discharge of their duties.
b) Compose an agenda for their year of service prior to assuming the position of Chair, with the assistance of the current Chair.
c) Be an ex officio, non-voting member of the Governing Council.
~~c)~~d) Rise to the position of Chair should the position become vacant prior to the end of the Chair's term.

~~8.~~9. **Immediate ~~-~~Past Chair.** The Immediate ~~-~~Past Chair shall:
a) Provide continuity in the leadership of the Section.
b) Be an ex officio, non-voting member of the Governing Council.

F. Terms.

1. Governing Council members shall serve one-year terms, beginning at the conclusion of the Annual meeting at which they were elected and ending at the conclusion of the next Annual meeting of the AMA. This provision shall not be applicable to the Chair, whose term ~~will~~ shall be two years, including six months as Chair-Elect and six months as Immediate ~~-~~Past Chair.

~~1.~~2. The Immediate-Past Chair may be a graduate of the RFS.

~~2. Delegate, Alternate Delegate, Member at-Large, Speaker, Vice Speaker and Vice-Chair: serve one-year terms, beginning at the conclusion of the Annual meeting at which they were elected and ending at the conclusion of the next Annual meeting of the AMA.~~

3. **Tenure.** Members are limited to two ~~one-year~~ terms per position, up to a maximum of four total years, consecutive or nonconsecutive, on the Governing Council, with the ~~following~~ exception~~s~~ of the Chair who shall be restricted to one Chair term as defined by E.1.1.~~:~~

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~~a) Chair-Elect/Chair/Immediate Past Chair: may serve up to two previous one-year terms before election to Chair-Elect~~
~~b) Delegate: may serve two terms as Delegate, consecutive or nonconsecutive, in addition to two other one-year terms~~
~~c) Speaker: may serve two terms as Speaker, consecutive or nonconsecutive, in addition to two other one-year terms~~
~~d) The limits shall be waived should their enforcement result in a position being left vacant.~~

4. Positions entered into after the official start of the term shall not count towards the above term limits.

G. Vacancies. Any vacancy occurring on the Governing Council not filled by the procedures outlined in Section IV.E shall be filled at the next Business Meeting of the Resident and Fellow Section. The new members shall be elected for the remainder of the unexpired term by the representatives to the Business Meeting.

1. **Temporary Appointment.** If a vacancy on the Governing Council occurs more than thirty (30) days prior to the next Business Meeting, the Governing Council may appoint an RFS member to fill the vacancy until the next Business Meeting when an election shall be held pursuant to rules adopted by the RFS.

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V. Elections and Endorsements

A. Time~~e~~ing of Election~~s~~ and Endorsements~~.~~

1. The following elections shall be held ~~at~~ during the RFS Interim Business Meeting:
   a) Governing Council: Chair-Elect.
   b) Sectional Delegates and Sectional Alternate Delegates.
   c) Endorsements for elections that take place at the next Annual meeting of the AMA House of Delegates including, but not limited to, ~~RFS~~ the resident/fellow position on the Board of Trustees and ~~RFS~~ the resident/fellow position on elected AMA Councils.

2. The following elections shall be held at the RFS Annual Business Meeting:
   a) Governing Council: Vice Chair, Speaker, Vice Speaker, Delegate, Alternate Delegate, and Member At-Large.

3. The Governing Council shall set the timeframe of the elections and endorsements in advance of each respective meeting.
   a) Between meetings, only campaigns for positions electable at the upcoming meeting are permitted.
   ~~3.~~b) All activities related to announcement of candidacy, endorsement, or campaigning—including, but not limited to: distribution of materials, communications, and speaking opportunities—shall be

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limited to the campaign period defined above by the Governing Council.

B. Nominations. Nominations for all elected positions shall be received in accordance with deadlines determined by the Governing Council. Candidates may self-nominate or be nominated by another member of the RFS. ~~Further~~ Additional nominations may be made from the floor at the Business Meeting at a time determined by the Governing Council.

C. Eligibility.

1. All members of the RFS are ~~be~~ eligible for elected positions and endorsements. RFS members may not hold concurrent positions on the RFS Governing Council, Board of Trustees, or Councils with the exception of RFS Chair-Elect or Immediate-Past Chair. All candidates, including candidates for Sectional Delegate and Sectional Alternate Delegate, must formally disclose to voters prior to the election any portion of their term during which they will not meet membership requirements.

2. **Cessation of Eligibility.** If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.11 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member ceases to meet the membership requirements of the RFS within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office until the completion of the Annual Meeting.

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D. Campaigns.

1. Each candidate shall observe the following Campaign Rules, which shall be overseen and moderated by the RFS Speakers and the Rules Committee:
   a) Candidates may not distribute ~~only the following~~physical campaign materials, including, but not limited to: buttons, stickers, pins, business cards, trinkets, posters, candy, pens, or other items.
      ~~(1) Buttons (less than 2 inches in greatest dimension).~~
      ~~(2) Stickers.~~
      ~~(3) Pins.~~
      ~~(4) Standard-size business cards.~~
      ~~(5) No trinkets, posters, candy, pens, or other items may be displayed or distributed.~~
   b) Candidates shall follow all application requirements and restrictions included in the nomination packet.
      ~~b)~~(1) Election materials of declared candidates for RFS leadership positions shall be posted online for review by RFS membership in advance of that election's respective national meeting.
   c) Candidates should be prudent and courteous regarding ~~the number and content of advance mailings by themselves or~~

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~~constituent associations, specialty organizations, or other organizations on their behalf.~~ their campaign communications.

(1) Non-electronic mailings by candidates or other organizations on behalf of a candidate are not permissible.

(2) Candidates should be prudent and courteous regarding the number and content of electronic messages, including, but not limited to: email, social media, phone, text message, and group chats, sent prior to the election.

(3) No mode of RFS- or AMA-sponsored communication, including, but not limited to: listservs, phone or email lists, or other mass communication methods shall be used for announcements of candidacy, endorsement, or campaigning unless sanctioned by the Governing Council.

~~c)~~(4) Candidates using campaign-specific social media accounts may only invite RFS members to follow said accounts and must provide an appropriate disclaimer to this effect on any such solicitation. Candidates shall not be penalized for any non-RFS members that happen to follow the account.

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d) Only RFS members may solicit support for a candidate.

~~d)~~e) Receptions and/or hospitality must not be used for promotion of a candidate for an RFS endorsement or election to an RFS position. Groups (~~such as Regions or Caucuses~~including, but not limited to, Standing Committees) inviting candidates must make available equal time for all candidates and provide reasonable and equal advance notice to all candidates about the opportunity. If a group is unable to reasonably accommodate all candidates, no candidates shall be allowed to address the group. ~~This rule shall not apply to a candidate addressing their own region.~~

~~e) Alleged infractions including but not limited to the Campaign Rules stated above should be reported in writing to the AMA-RFS Speaker, Vice-Speaker, and Rules Committee, who shall be responsible for the investigation. The AMA-RFS Speaker or Vice Speaker will report substantiated infractions to the Assembly at the Business Meeting prior to balloting and the Assembly should strongly consider any such announcement when voting for candidates.~~

f) **Neutrality of Governing Council During Elections.** Governing Council members should not share their opinion in favor or in opposition to any candidate while acting in their official capacity. If a Governing Council member does share their opinion regarding a candidate, that member should explicitly state that they are speaking as an individual. ~~That our AMA-RFS~~ Governing Council members shall maintain a neutral status in elections by:

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~~(1) Not wearing campaign materials, except their own.~~

~~(2)~~(1) Not acting as campaign manager for any candidate.

~~(3)~~(2) Not endorsing candidates from the podium.

~~(4)~~(3) Not endorsing candidates as a Council.

(4) Not endorsing candidates through ~~the~~ use of one's Governing Council title.

(5) Not following campaign pages of candidates. The Speaker and Vice Speaker are exempt from this provision for the purposes of monitoring adherence to the Campaign Rules.

~~(6) Using discretion with respect to their personal endorsements.~~

2. **Infractions.**

a) **Investigators and Investigative Process.** The Speaker and Vice Speaker shall be the lead investigators of any alleged infraction in conjunction with the Rules Committee. No person who is a candidate in the same election as the candidate being investigated for alleged infractions shall participate in any part of the investigation of those alleged infractions.

b) In the event where both the Speaker and Vice Speaker are candidates for the election being investigated, the RFS Chair shall designate two members of the Rules Committee as investigators to examine the alleged infraction.

c) **Rebuttal Process.** Rebuttal occurs during an investigation where the alleged violator is given the opportunity to defend the actions in the alleged infraction. Following this, the investigators shall report substantiated infractions to the Assembly but shall not make any recommendation to the Assembly. Upon each substantiated infraction of the Campaign Rules, the candidate shall be given an official warning letter from the Speaker.

d) **Candidate Disqualification Process.** If a candidate exceeds three (3) substantiated infractions, the Governing Council shall convene to determine whether to disqualify the candidate for that election.

e) **Appeals Process.** Appeals occur after a determination of whether an infraction is substantiated or after a determination of whether a candidate should be disqualified. Appeals focus on the process of the investigation or determination. Should a candidate feel that due process was not followed in either of these cases and that an appeal is warranted, they must submit this in writing to the Governing Council investigators within 24 hours of being notified of the result. The Governing Council shall convene to review the appeal and determine whether the previous decision should be reversed. Both the alleged violator and reporter shall be offered the opportunity to provide comments on whether the appeal is justified. Whenever possible, an appeal should be reviewed prior to the results of the investigation being released to the Assembly.

3. **Voter Eligibility.** All credentialed RFS Business Meeting Delegates and Business Meeting Alternate Delegates shall be eligible to vote. ~~Absentee ballots are not accepted. Members with conflicts should~~

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~~seek permission from their Council, State or specialty to vote on items of business being considered by the Assembly.~~

E. **Endorsement.** Candidates may seek endorsement from their program, state society, specialty society, Federal Service, or professional interest medical society (PIMA). Any endorsement of a resident or fellow member shall only be considered valid for one election cycle, which includes the meeting during which the initial endorsement was obtained. If a resident or fellow member is seeking re-endorsement following expiration of previous endorsement, the member would be required to obtain a new endorsement from the relevant ~~program, hospital, or society~~party.

F. **Speeches.** Candidates are allowed to address the Assembly in a manner to be designated by the Speaker and Vice Speaker. With the exception of the Sectional Delegate and Sectional Alternate Delegate elections, the Speakers shall also design an opportunity for the candidates to respond to questions in front of the Assembly.

~~H.~~G. Method of Election and Endorsement.

1. **Governing Council Elections.**
   a) **Uncontested elections.** ~~:~~ If after the call for nominations there is only one candidate for a ~~position~~n office, the race shall be considered uncontested and the election shall be by acclamation, which shall be held immediately after the call for nominations.
   b) **Contested elections**~~:~~**.** If after the call for nominations there is more than one candidate for an office ~~position~~, that race shall be considered contested, and the following method shall be used to elect:
      (1) Elections shall use a ranked-choice voting system, according to the following procedures:
         (a) Ballots for Chair-Elect, Vice Chair, Delegate, Speaker, and Member At-Large shall list candidates alphabetically by last name.
         (b) Ballots shall allow voters to rank their preferred candidates for each office, where the number of candidates ranked shall equal the number of total candidates running for that office.
         (c) If a candidate receives a simple majority of first preference votes cast for a given office, they shall be elected to that office.
         (d) If no candidate receives a simple majority of first preference votes on the first ballot, the candidate with the fewest first preference votes shall be eliminated and ballots ranking them as first preference shall be retabulated to distribute votes to the next most-preferred candidate according to each ballot. This process shall repeat until a

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candidate receives the simple majority of first preference votes, at which time such candidate shall be elected to that office.

~~(1) Ballots for each position shall be listed in alphabetical order and used by the voter with one vote for each of the following positions: Chair-Elect, Vice Chair, Delegate, Speaker, and Member At Large.~~

~~(2) A ballot shall not be counted if there is more than one vote for any office on that ballot.~~

~~(3) The candidate who receives a majority of legal ballots cast for a given office shall be elected to that office. If no candidate receives a majority on the first ballot, a runoff election shall be held between the candidates receiving the first and second largest number of votes.~~

~~(4)~~(2) **Election of Alternate Delegate.** After the election of the Delegate, all unsuccessful candidates who were nominated for the office of Delegate, and who choose to be a candidate for Alternate Delegate, ~~will~~ shall be placed on a ballot for the election of the Alternate Delegate. Additionally, any candidate who was nominated for the office of Alternate Delegate shall also be placed on the same ballot. ~~Each voting Representative to the Business Meeting who is present at the meeting may cast a ballot for the election of the Alternate Delegate from among those so nominated. Election to the office of Alternate Delegate requires a majority of the legal ballots cast. The remaining rules for election balloting in V.G.1.b.3 will apply~~Election of Alternate Delegate shall use the ranked choice voting system described in V.G.1.b.1. If there is only one candidate for Alternate Delegate, the race shall be considered uncontested and the election shall be by acclamation, which shall be held immediately after the call for nominations.

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~~(5)~~(3) **Election of Vice Speaker.** After the election of the Speaker, all unsuccessful candidates who were nominated for the office of Speaker, and who choose to be a candidate for Vice Speaker, ~~will~~ shall be placed on a ballot for the election of the Vice Speaker. Additionally, any candidate who was nominated for the office of Vice Speaker shall also be placed on the same ballot. ~~Each voting Representative to the Business Meeting who is present at the meeting may cast a ballot for the election of the Vice Speaker from among those so nominated. Election to the office of Vice Speaker requires a majority of the legal ballots cast. The remaining rules for election balloting in V.G.1.b.3 will apply~~Election of Vice Speaker shall use the ranked choice voting system described in V.G.1.b.1. If there is only one candidate for Vice Speaker, the race shall be considered uncontested and the

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election shall be by acclamation, which shall be held immediately after the call for nominations.

2. **Endorsement for ~~RFS~~ resident/fellow position on the Board of Trustees and elected Councils.**
   a) Only one RFS member may be endorsed at the Business Meeting for each position. The endorsement shall be for a single election cycle and shall occur at the Interim ~~meeting~~Business Meeting. ~~The credentialed delegates may choose not to endorse any candidate.~~
   b) Voting for endorsements shall use the ranked-choice voting system, according to the following procedures:
      (1) Ballots for each office shall list candidates alphabetically by last name.
      (2) Ballots shall allow voters to rank their preferred candidates for each office, where the number of candidates ranked shall equal the number of total candidates running for endorsement for that office.
      (3) If a candidate receives a simple majority of first preference votes cast for a given office, they shall be endorsed by the RFS for that office.
      (4) If no candidate receives a simple majority of first preference votes on the first ballot, the candidate with the fewest first preference votes shall be eliminated and ballots ranking them as first preference shall be retabulated to distribute votes to the next most-preferred candidate according to each ballot. This process shall repeat until a candidate receives the simple majority of first preference votes, at which time such candidate shall be endorsed by the RFS for that office.
   ~~b) The ballot shall contain the name of each candidate as well as an option to select none of the candidates. On the ballot, affirmative votes may be cast for one candidate or no candidates.~~
   ~~c) A candidate must receive a majority of legal votes to be endorsed. If no candidate receives a majority of votes, a runoff election shall be held between the candidates receiving the first and second highest number of votes.~~
   ~~d)~~c) **Late Endorsement.** At the time of the RFS Annual Meeting, if no candidate has been endorsed, a candidate may seek endorsement by the Assembly. This is subject to the same rules described above ~~and additionally requires a 2/3 affirmative vote of the Assembly for endorsement~~.

3. **Election of the Sectional Delegates and Sectional Alternate Delegates.**

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a) Candidates may seek endorsement from their ~~program,~~ state society, specialty society, Federal Service, or PIMA. All nominees for Sectional Delegate shall be listed on a single ballot with their endorsing society. Candidates who receive written endorsement from their endorsing constituent association or specialty society prior to the election shall be noted to indicate that their endorsing materials were received prior to the election.

b) The voter must vote for exactly as many candidates as there are open positions.

c) ~~Ballots will be counted and d~~Delegates selected based on a majority of approval voting system.

d) Should a candidate be successfully elected without a prior endorsement, ~~-~~ they ~~have30~~ have 45 days to obtain and submit written notification of endorsement from an organization consistent with Section VIII.B.2.a. If such requirements are not met, the position shall be considered vacant.

e) **Limitations.** ~~There shall be a limit of two Sectional Delegates and two Sectional Alternate Delegates per state or specialty society.~~ Only two nominees from an endorsing state or specialty society shall be elected unless this limit results in a vacancy in the RFS delegation.

~~(1) If there are more than two nominees from an endorsing state or specialty society who receive a majority of votes, then only the two nominees who have the most votes shall be elected.~~

~~(2) All other nominees from that society shall be eliminated from the remaining counting of ballots. This process will continue throughout the counting of ballots to ensure that there are only two RFS Sectional Delegates per endorsing state and specialty society.~~

f) **Unfilled Seats/Runoff Elections.** If there are unfilled seats after the election, a runoff election shall be held between the remaining candidates. The candidate(s) who receive(s) the highest number of votes, with a majority of legal votes cast, shall be elected.

~~f)~~

~~(1) If there are unfilled seats after the election, a runoff election will be held between the remaining candidates. The candidate(s) who receive(s) the highest number of votes, with a majority of legal votes cast, shall be elected.~~

~~(2) If unfilled seats remain after elections are completed, one additional Sectional Delegate and Alternate Delegate per endorsing state/specialty society will be allowed in a subsequent balloting period. This process will continue through as many counting rounds as needed until all Sectional Delegate seats are filled.~~

g) **Sectional Alternate Delegate Elections.**

(1) After the completion of the Sectional Delegate elections, all unsuccessful candidates ~~will~~ shall have the option to be considered in the election for Sectional Alternate Delegate alongside those candidates who ran specifically for Sectional Alternate Delegate.

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(2) The Sectional Alternate Delegate elections shall follow the same procedure as the election for Sectional Delegates.

~~4. Election of Regional Leaders.~~

~~a) Timing. Election of a Regional Chair shall occur during the Annual Business Meeting.~~

~~b) Method. Election shall occur by in-person balloting. No proxy votes are allowed. The candidate receiving a majority of the votes will be elected Regional Chair.~~

~~c) Additional Positions. Additional positions will be elected consistent with the method for the Regional Chair. Additional positions will be designated at the discretion of the Governing Council or Regional Council.~~

~~5.~~4. **Balloting.** Method of balloting ~~will~~ shall be coordinated by the staff, Speaker, and Vice Speaker in concurrence with the Rules Committee.

a) Ballot information~~s will~~ shall be prepared and distributed by ~~the Credentials Committee~~AMA staff.

b) No ballots ~~will~~ shall be cast after the expiration of each voting period. Upon completion of ballot counting, the ~~Chair of the Rules Committee will~~ Business Meeting's presiding officer shall validate the election results~~ by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed and will then certify the results of the election. They will then immediately forward these results to the Business Meeting's presiding officer.~~

c) Upon receipt of the ~~Rules Committee~~ election results~~ and verification~~, the Business Meeting's presiding officer ~~will~~ shall certify the results of these elections and announce to the Assembly the final and official results of these elections. Vote totals shall remain confidential and shall not be announced. Candidates may ask for and receive vote totals in confidence.~~ Discretion is encouraged.~~

~~6.~~5. **Appeals.** Appeals of the election process and results must be made in writing to the ~~Speaker~~ presiding officer no later than one hour after the official announcement of the final results or prior to adjournment of business on the day elections are held, whichever comes later.

a) Any appeal of the process of ballot(s) distribution, ballot election, tabulation, and announcement of results ~~(as outlined in RFS Internal Operating Procedures V.E.2) will~~shall be considered by the Rules Committee. Consideration of such appeals and merits of said appeals ~~will~~ shall be determined in whatever manner the committee deems necessary. The results of the committee's recommendations ~~must~~ shall be forwarded in writing by the Committee Chair to the Speaker.

~~(1) Any appeal of the process of ballot election, tabulation and announcement of results (as outlined in RFS Internal Operati Procedures V.E.7.a) shall be considered by the Rules Committee in the same manner as outlined in RFS Internal Operating Procedures V.E.7.a.~~

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a) ~~b)~~ The Assembly's presiding officer and the preceding Governing Council at the Annual Meeting or the present Governing Council at the Interim Meeting ~~will~~ shall consider the appeals reports from the committee(s) dealing with the matter. Final decision on the election results ~~will~~ shall be the jurisdiction of the Governing Council as described above.

H. **Limitation.** The procedures outlined in this Section shall apply only to elections and endorsements taking place within the RFS and shall not be construed to govern elections conducted by other groups within the AMA or the House of Delegates.

VI. Resident/Fellow Member on the Board of Trustees

A. Endorsement. The RFS may choose to endorse a member to run for the Board of Trustees in accordance with Section V.~~I~~G.2.

B. Duties and Privileges.

1. **Report at the Business Meeting.** An opportunity ~~will~~ shall be provided to the Resident/Fellow Trustee to ~~submit a report~~provide an update of the Board of Trustee's activities to the Assembly ~~biannually~~twice yearly.
2. The Resident/Fellow Trustee shall be subject to the privileges and duties of all AMA Trustees as outlined in the AMA Bylaws Section 5.
3. The Resident/Fellow Trustee shall represent the voice of ~~the~~ residents and fellows on the Board and may provide guidance to the Governing Council and RFS standing committees.

C. Term. The term for membership on ~~T~~the Board of Trustees shall be in accordance with AMA Bylaws Section 3.5.5.

D. Vacancies. Any vacancy ~~occurring on~~of the resident/fellow member position on the Board of Trustees shall ~~require a new endorsement election in accordance with IOP section V.I.2 at the next Business Meeting, who shall then be considered by the full House of Delegates in accordance with AMA Bylaws Section 3~~be handed in accordance with AMA Bylaws Section 3.6.

VII. Resident/Fellow Member on AMA Councils

A. Selection.

1. **Elected Councils.** AMA Councils with an elected resident/fellow position are: Council on Medical Service, Council on Medical Education, Council on Constitution and Bylaws, and Council on Science and Public Health. ~~Elections~~ RFS endorsements shall be ~~conducted~~ determined in accordance with Section V.~~I~~G.2.

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2.3. **Appointed Councils.** Selection to Councils with an appointed resident/fellow position are: Council on Long Range Planning and Development, Council on Ethical and Judicial Affairs, and Council on Legislation. Appointments ~~will~~ shall be conducted in accordance with Section X.

B. Duties and Privileges.

1. **Report at the Business Meeting.** An opportunity ~~will~~ shall be provided to the resident/fellow member of all Councils to ~~submit a report~~provide an update of the Council's activities at the Business Meeting ~~biannually~~twice yearly.

2. Council members shall be subject to the privileges and duties outlined in the AMA Bylaws Section 6.

3. Council members may provide guidance to the Governing Council and RFS standing committees in accordance with Section XI.E.

4. Council members shall not speak on behalf of the RFS in the House of Delegates unless first permitted ~~to~~ by the RFS Delegate or Alternate Delegate.

C. Term. The term for membership on each Council shall be in accordance with AMA Bylaws Section 6.

D. Vacancies. Vacancies occurring on the Councils before completion of the term shall be filled at the next opportunity, following the same method as the resident/fellow member would normally be selected.

VIII. Sectional Delegates and Alternate Delegates to the House of Delegates

A. Apportionment. The RFS is entitled to delegate and alternate delegate representation in the House of Delegates based on AMA Bylaws Section 2.4.2.

B. Election. All elections ~~will~~ shall be conducted in accordance with Section V.G~~I~~.3.

C. Duties and Privileges.

1. Sectional Delegates and Alternate Delegates shall be subject to the privileges and duties of all AMA delegates as outlined in the AMA Bylaws.

2. Sectional Delegates and Alternate Delegates shall caucus with their endorsing society as well as assist the RFS Delegate and Alternate Delegate in representing the Resident and Fellow members of the AMA in the House of Delegates.

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3. RFS Sectional Delegates and Alternate Delegate shall not speak on behalf of the RFS unless first permitted to by the RFS Delegate or Alternate Delegate.

4. Sectional Delegates and Alternate Delegates shall be responsible for reporting back to the resident and fellow members of their state or specialty endorsing society regarding the activities of the AMA House of Delegates as applicable.

D. Seating.

1. Sectional Delegates shall be seated with their endorsing state or specialty society. ~~In the case where a Sectional Delegate has been endorsed by both his or her state and specialty society, they must choose with which delegation they wish to be seated.~~

2. A Sectional Alternate Delegate appointed to fill a Delegate vacancy shall sit with the endorsing society of the Sectional Delegate.

E. Limitations.

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

2. The aforementioned limits shall be waived should their enforcement create vacancies in the position of Sectional Delegate or Alternate Delegate at the discretion of the Delegate and Alternate Delegate.

3. None of these limits shall be construed to limit the number of residents or fellows who can be endorsed by any given state or specialty society for the RFS Sectional Delegate and Alternate Delegate election.

F. Term.

1. The normal term shall commence with the close of the House of Delegates Interim Meeting that immediately follows ~~his or her~~their election and shall end at the close of the following Interim Meeting of the House of Delegates.

2. Should an existing Delegate or Alternate Delegate cease to meet membership requirements as defined in Section III prior to the expiration of the position's term, the position ~~will~~ shall be vacated.

G. Vacancies.

1. Sectional Delegate vacancies shall be filled by ~~a temporary~~ appointment from the available Sectional Alternate Delegates ~~at the discretion of~~by the RFS Delegate and Alternate Delegate.

2. Sectional Alternate Delegate vacancies shall be filled by ~~a temporary~~ appointment of RFS members ~~present at the current House of Delegates meeting at the discretion of~~by the RFS Delegate and Alternate Delegate.

~~2.~~3. Sectional Delegate and Sectional Alternate Delegate vacancies shall be filled according to procedures established by the Governing Council.

~~3. Temporary appointments shall last for the duration of the House of Delegates meeting during which the appointment was made.~~
~~a) Consideration in temporary appointments shall be given to members who maintain or increase diversity of RFS representation in the House of Delegates with regards to sponsoring state and specialty societies.~~

IX. Business Meeting

There shall be a meeting of resident and fellow members of the AMA-RFS held on a day prior to each meeting of the AMA House of Delegates.

A. Definition. Meetings of the Resident and Fellow Section shall be known as Business Meetings.

B. Purpose. The Business Meeting represents the core work of the RFS and shall occur prior to each meeting of the AMA House of Delegates. The purposes of the meeting shall be:

1. To hear reports as ~~are~~ appropriate.
2. To elect the Governing Council of the RFS and to endorse RFS members for AMA Councils and AMA Board of Trustees.
3. To elect Sectional Delegates and Alternate Delegates to represent the RFS within the AMA House of Delegates.
4. To deliberate and adopt resolutions ~~to guide the internal discussions and deliberations~~determining policy of the RFS and, where necessary, forward these resolutions for consideration to the House of Delegates of the AMA.
5. To conduct such other business as may properly come before the meeting.
6. To provide programming to educate and inform members of topical issues in medicine, medical education, and public health.
~~6.~~7. To provide ~~value~~ opportunities for members ~~including adequate time~~ during and after the meeting for socializing, camaraderie, and networking.

C. Representatives to the Business Meeting from Organizations represented in the House of Delegates. The Business Meeting shall include representatives from constituent associations, Federal Services, national medical specialty societies, and professional interest medical associations represented in the House of Delegates.

1. **Apportionment.** The apportionment of each constituent association, Federal Service, national medical specialty society, and professional interest medical associations is one representative per 100, or fraction thereof, members of the Resident and Fellow Section who are members of the constituent association, Federal Service, national medical specialty society, or professional interest medical association.

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2. **Effective Date.** The AMA Bylaws Section 2.1.1.1 sets the date of effect and the length of apportionment.

D. Other Representatives to the Business Meeting.

1. At-Large ~~Representatives~~Delegates. Active RFS members of the AMA may be eligible to serve as at-large ~~representatives~~ delegates to the ~~Resident and Fellow Section~~ Business Meeting.

a) **Apportionment.** The number of ~~representatives~~ delegates shall be 10% of the ~~average~~ number of registered RFS delegates and alternate delegates from the previous ~~year~~Annual or Interim Business Meeting, respectively.

b) Criteria for the At-Large Delegate positions include the following:
   (1) A candidate must be an AMA-RFS member;
   (2) A candidate must submit an application to the RFS Governing Council for consideration. In the event that all available At-Large positions are not filled by application to the Governing Council, these positions may be filled at the meeting (Annual or Interim) on a first-come, first served, basis.

c) **Term.** A candidate ~~will~~ shall be able to apply to serve in this position for one meeting (Interim or Annual) or for an academic year. Final determination shall be at the discretion of the Governing Council.

d) **Limits.** There are no term limits for these positions but candidates must reapply after each year or meeting at the discretion of the Governing Council.

~~e) Vacancies. All vacant positions after Interim will be offered for Annual.~~

2. National Resident and Fellow Organizations.

a) **Apportionment.** Each national resident and fellow organization that has been approved for representation in the RFS Assembly may select one representative and one alternate representative.

b) **Criteria for Eligibility.** National medical resident and fellow organizations that meet the following criteria may be considered for representation in the ~~AMA Resident and Fellow Section~~ Business Meeting:
   (1) The organization must be national in scope.
   (2) The organization must be composed ~~solely~~ primarily of residents and/or fellows.
   (3) Membership in the organization must be available to all residents or fellows, without discrimination.
   (4) The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives.
   (5) The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.

c) **Procedure.** The organization must submit a written application containing sufficient information to establish that the organization meets the criteria described above. The application ideally should also include the following:
   (1) The charter, constitution, bylaws, and code of medical ethics of the application organization.

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(2) A list of the sources of financial support, other than membership dues, of the applicant organization.
(3) A list or description of all affiliated organizations with the applicant organization.
(4) Such additional information as may be requested.

d) The Governing Council shall review the application and make a recommendation to the RFS Assembly regarding whether~~. If it recommends that~~ the organization be granted representation in the ~~Resident and Fellow Section~~ Business Meeting~~, the recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the organization may be represented in the Resident and Fellow Section Business Meeting~~. The Assembly shall then vote to determine whether the organization shall be granted representation in the Business Meeting.

(1) Organizations that seek membership within the RFS primarily shall also be encouraged to concurrently pursue membership to join the AMA's House of Delegates.

e) **Biennial Review Process.** Each national resident and fellow organization represented in the Resident and Fellow Section Business Meeting must reconfirm biennially that it continues to meet the criteria for eligibility by submitting such information and documentation as may be required by the Governing Council.

f) **Rights and Responsibilities.** Representatives of national resident and fellow organizations in the Resident and Fellow Section Business Meeting shall have the following rights and responsibilities:

(1) ~~Full v~~Voting rights in the Business Meeting, ~~except~~ with the exception of the right to vote in any elections~~, at~~ until the conclusion of a ~~two-year~~one meeting probationary period ~~with regular attendance~~.
(2) Presenting its policies and opinions in the Business Meeting.
(3) Reporting on the actions of the RFS to members of their respective organizations.
(4) Cooperation in enhancing the AMA Resident and Fellow Section membership.

g) **Discontinuation of Representation.** The Governing Council may recommend discontinuation of representation by a national resident and fellow organization on the basis that the organization fails to meet the above criteria and responsibilities, or has failed to attend the Business Meeting of the RFS. The recommendation shall be submitted to the ~~AMA Board of Trustees~~RFS Assembly for review. If ~~approved~~ voted for by the ~~AMA Board of Trustees~~RFS Assembly, the representation of the national resident and fellow organization in the RFS Business Meeting shall be discontinued.

~~(1) National resident and fellow organizations that are recommended for discontinuation of representation shall have the opportunity to petition the Assembly for reconsideration. This petition can be submitted to the Governing Council at the subsequent meeting after being informed that their representation is recommended for discontinuation.~~

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~~(2)~~(1)If a national resident and fellow organization wishes to challenge its recommendation for representation discontinuation, both the Governing Council and the organization shall submit reports to the Assembly detailing their arguments. These reports shall be considered together as the first items of business in the RFS Business Meeting and decided by a simple majority vote.

~~(3) Should the Assembly vote to recommend discontinuation of membership, the recommendation shall be forwarded to the AMA Board of Trustees. Should the credentialed delegates vote to not recommend discontinuation of membership, the national resident and fellow organization shall retain its membership within the RFS.~~

3. **Official Observer.** National resident and fellow organizations may apply to the RFS Governing Council for official observer status at the RFS Business Meeting. Applicants and official observers must demonstrate compliance with guidelines for official observers adopted at the RFS Business Meeting, and the Governing Council shall make a recommendation at the RFS Business Meeting concerning the application. The AMA-RFS Assembly ~~will~~ shall make the final determination on conferring or continuing official observer status. Organizations with official observer status are invited to send one representative to observe the actions of the Assembly at all RFS Business Meetings. Official observers have the right to speak and debate on the floor of the Business Meeting upon invitation from the Speaker. Official observers do not have the right to introduce business, introduce ~~an~~ amendments, make ~~a~~ motions, or vote.

E. Credentialing. The names of the duly selected voting RFS Business Meeting Delegates and Alternate Delegates from each state and specialty society should be received by the Director of Resident and Fellow Services of the AMA at least 45 days prior to the start of the Business Meeting in writing. Prior to the start of business on each day of the Business Meeting, credentialing ~~will~~ shall take place, where voting members must officially identify themselves to the Credentialing~~s~~ Committee as ~~having been~~ duly selected ~~to~~ representatives of their state society, specialty society, or branch of the armed services.

~~1. Registered RFS members whose clinical responsibilities and travel arrangements require them to arrive during a day's business but after the close of credentialing may, at least four weeks prior to the meeting, petition the Governing Council to be allowed to credential late for the meeting. The decision to allow an RFS member to credential late will be made by majority vote of the Speaker, Vice Speaker, Delegate, Alternate Delegate, and Chair of the Rules Committee and communicated to the RFS member and the Credentialing Committee, in writing at least two weeks prior to the start of the meeting.~~

~~2.~~1. Previously registered RFS members who miss credentialing ~~due to unforeseeable travel delays~~ may~~, on a case-by-case basis~~ be allowed to credential late for that day's business if late credentialing is approved~~.~~

~~This would be determined~~ by a majority vote of the Speaker, Vice Speaker, and Chair of the Rules Committee~~, and communicated to the RFS member and the remainder of the Credentialing Committee~~.

~~3.~~2. Only credentialed RFS members present in the Business Meeting ~~room~~ may vote on items of business being considered.

F. Participation.

1. All RFS members have the right to testify on the floor of the Business Meeting. Only duly selected Assembly Delegates and Alternate Delegates to the assembly meeting shall have the right to vote~~, but the meeting floor and the right to testify shall be open to all residents and fellow members of the AMA~~. The Presiding Officer of the Assembly may grant a non-RFS member the privilege of the floor.

2. If the RFS Immediate~~ Past Chair of the Governing Council~~ no longer meets membership requirements, they shall have the same "speaking" privileges at the RFS Business Meeting as any other member of the Governing Council, excluding the privilege to make a motion~~, in RFS Business Meeting as any other member of the Governing Council~~.

G. Procedure.

1. **Agenda.** Prior to Business Meetings, ~~the agenda~~ the agenda shall be made available for RFS members to view. The order of business ~~will~~ shall be set by the Speakers prior to the meeting. The Assembly at any time may change the order of business by a majority vote.

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2. **Rules of Order.** The Business Meeting shall be conducted pursuant to the established rules of procedure submitted by the Speakers and adopted by the Assembly. The Rules of Order that govern the AMA House of Delegates shall govern the Business meeting of the RFS in all matters not outlined in the adopted rules of procedure mentioned above.

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3. **Quorum.** Twenty percent (20%) of the credentialed Delegates shall constitute a quorum so long as at least 15 different states and five national medical specialty associations, military, or federal agencies are represented.

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4. For the purposes of quorum, members allowed special dispensation from the credentialing timeline as described in Section IX.E.1 shall not be counted as present.

H. Resolutions. Any ~~resident and fellow~~RFS member may submit resolutions for consideration at the ~~RFS~~ Business Meeting.

1. An official record of previous actions of the Assembly shall be maintained and made available to RFS members to preserve the work and institutional memory of the RFS.

2. **Deadlines.** All resolutions must be received by the RFS staff by a deadline determined by the Governing Council no later than 45 days before the Business Meeting to be considered as regular business. They ~~will~~ shall be made available to the Section and are debatable on the floor at the Business Meeting.

3. The deadlines for submission ~~will~~ shall be posted to the RFS website.

4. **Late Resolutions.** Resolutions that are submitted after the 45-day deadline but 7 days prior to the Business Meeting being called to order shall require a two-thirds vote of the Assembly to be debatable on the floor. The Rules Committee shall make recommendations to the Assembly on whether individual items should be considered as business. Late resolutions approved for consideration shall be referred to a reference committee and handled in the same manner as those resolutions introduced before the 45-day deadline.
   a) Debate on consideration of late resolutions shall be focused on timeliness of the resolution for the meeting, and not on the merits or content of the resolution.

   ~~5.~~b) Authors of late resolutions not accepted as business by the RFS Assembly have the option to request automatic submission of the resolution to the next ~~RFS~~ Business Meeting.

~~6.~~5. **Emergency Resolutions.** Resolutions that are submitted within 7 days of the Business Meeting, or after commencement of the meeting, shall require a ~~three-fourths~~two-thirds vote of the Assembly to be debatable on the floor. The Rules Committee shall make recommendations to the Assembly on whether individual items should be considered as business. Emergency resolutions approved for consideration prior to the start of the reference committee open hearing shall be referred to a reference committee and debated on the floor. Emergency resolutions approved for consideration after the start of the reference committee open hearing shall be debated on the floor at the Business Meeting without referral to a reference committee.
   a) Debate on consideration of emergency resolutions shall be focused on timeliness of the resolution for the meeting, and not on the merits or content of the resolution.
   b) Authors of emergency resolutions not accepted as business by the RFS Assembly have the option to request automatic submission of the resolution to the next ~~RFS~~ Business Meeting.

~~7.~~6. All resolutions approved for consideration as business shall require a simple majority vote of the Assembly for adoption except those amending the IOPs, which require a two-thirds vote as specified in Section XIII.B.

7. Resolutions and reports introduced by the Governing Council shall read, "Submitted by: RFS Governing Council.". Such items may only be submitted when there is majority approval by all voting members of the Governing Council.

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8. All resolutions submitted to the RFS shall be assumed to be internally-directed only and shall read “Resolved, our AMA-RFS…”.
   a) In the event that the resolution authors or the Assembly wish to have a resolution considered by the AMA House of Delegates, a final resolved clause reading “Resolved, that this resolution (or the appropriate resolved clauses) be forwarded to the AMA-HOD at (the appropriate meeting)” shall be included in the resolution. Should the resolution pass with this resolved clause intact, the resolution shall automatically be added to the RFS Digest of Actions reading “Resolved, our AMA-RFS...” but forwarded to the AMA HOD reading “Resolved, our AMA...” or other appropriate editorial change.

      (1) The actions on the resolution taken by the House of Delegates (including language changes) shall not change the result of the resolution within the RFS Digest of Actions or its sunset date.

I. Sunset Mechanism. The lifespan of any passed resolution is ~~ten~~ five years by default, at which point these items are considered for “sunsetting”. The Governing Council shall present actionable recommendations on these items via annual report, for review at the Interim meeting and action at the Annual meeting.

1. Each adopted resolved or recommendation clause shall be considered individually.

2. The recommendations available for each item considered are: reaffirm, rescind, reconcile with more recent and like items, or editorial changes that maintain the original intent.

3. Each item may individually be extracted from the report to be discussed by the Assembly, but only in the frame of adopting or not adopting the original recommendation.

4. Any action that retains or updates an item resets the sunset timeline.

~~5. Items may be included before the ten-year mark if their relevance has changed.~~

~~6.~~5. Defeated sunset recommendations extend the item ~~for one year, to be reconsidered~~until reconsideration in the next iteration of the Sunset Report.

J. Convention Committees. The Governing Council shall solicit applications for Convention Committees as necessary and, upon review, appoint the committees and support their execution. These committees are to expedite the conduct of business at each meeting of the Assembly.

1. Credentialing~~s~~ Committee. A ~~3- to 9-member~~ Credentialing~~s~~ Committee shall be ~~formed, including one Chair. The Committee shall be~~ responsible for

consideration of all matters relating to the registration and certification of delegates including credentialing delegates for business meetings, verifying a quorum is present, and distributing ballots for elections**.**

2. **Logistics Committee.** A Logistics Committee shall be ~~composed of 3 to 5 members. The Committee shall be~~ responsible for making the business of the Assembly ~~most readily available to the Assembly~~accessible to RFS members.

3. **Rules Committee.** A Rules Committee shall be composed of ~~5~~ an odd number of members, including one Chair. The committee shall:
   a) Review late and emergency resolutions and make recommendations to the Assembly on whether to consider them as business.
   b) Be familiar with the Rules of Order such that they can assist attendees throughout the Business Meeting.
   c) Collect and tabulate ballots for RFS elections, and count hand votes during the business meeting as requested by the Speakers.
   d) Prompt review of any alleged campaign infractions or election appeals with recommendations to the Governing Council for action.
   e) Perform any other tasks to facilitate the meeting at the discretion of the presiding officer.

4. **Reference Committee(s).** The number and membership of reference committees appointed for each RFS Business Meeting ~~will~~ shall be determined by the Speakers prior to each meeting.
   a) Each reference committee shall be composed of ~~5~~ an odd number of members ~~and one alternate unless, in the judgment of the Speakers, circumstances warrant an adjustment in the number of members on one or more reference committees~~. Each committee shall conduct an open hearing on items of business referred to it (resolutions and reports) and make recommendations to the Assembly for disposition of its items of business through the preparation of reference committee reports.

~~a)~~**5. Ad Hoc Convention Committees.** The Governing Council may establish additional Convention Committees as needed for any given Business Meeting.

~~5. **Hospitality Committee.** A Hospitality Committee shall be composed of at least 3 members. This committee shall have the responsibility of aiding the Speakers and Governing Council in providing an as member-friendly experience as possible for attendees of the conference, including organizing activities for socializing, camaraderie, and networking.~~

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X. Appointed Representation Outside of the Section

A. Positions Requiring Representation.

1. At least one member shall be recommended by the RFS Governing Council for consideration for appointment to the AMA Councils with an Appointed RFS position.

2. At least one member shall be recommended by the RFS Governing Council to the AMA Board of Trustees for consideration for appointment to the RFS

seat on the Liaison Committee on Medical Education (an AMA/AAMC joint committee).

3. At least one member shall be recommended by the RFS Governing Council for appointment to Governing Councils of other AMA Sections where such a position exists.

4. For all other RFS representation on behalf of the AMA, the ~~RFS~~ Governing Council shall recommend at least one member to the AMA Board of Trustees, or appropriate board or selection committee, for consideration.

B. **Application**. Recommendations from the Governing Council shall occur after a period of solicitation of applications and appropriate review by the Governing Council.

C. **Terms.** Residents and Fellows appointed shall serve in accordance with the AMA Bylaws.

XI. Standing Committees

A. **Composition.** The Governing Council shall annually appoint or reappoint standing committees aligned with the strategic goals of the RFS~~for Long Range Planning, Public Health, Medical Education, Legislation and Advocacy, Membership, Scientific Research, Quality and Public Safety, and Business and Economics~~. These committees shall be composed of members of the Section.

B. **Duration.** These committees ~~will~~ shall be appointed for one-year terms, and new committee chairs, vice-chairs, and members ~~will~~ shall be appointed on an annual basis. Additional short-term members may be appointed for the remainder of the term after the Interim Business Meeting.

C. **Selection.** The Governing Council shall make an open solicitation of applications from the members of the Section and shall select from among those who have applied. Should there be insufficient applications to adequately staff these committees, the Governing Council shall be empowered to make direct solicitations and appointments to the committees.

D. **Roles.** Each committee shall have, at a minimum, a Chair and Vice Chair selected by the Governing Council, tasked with creating goals and objectives for the committee for the following year.

E. **Duties and Privileges.** In alignment with their respective subject areas, committees shall be expected to propose programming for the education of RFS members, create reports as assigned by the Governing Council, provide feedback on relevant submitted resolutions and reports, and engage in other activities as deemed appropriate by the Governing Council.

~~1. **Committee on Business and Economics.** The committee shall address topics including but not limited to financial and economic issues affecting physicians during their residency and fellowship, and personal and practice finance issues. The committee may also develop and implement policies and~~

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~~directives of the Assembly that are related to the business and economics of residents, fellows, and medicine. The RFS member of the AMA Council on Medical Service shall serve as an ex officio member of this committee.~~

~~2. **Committee on Legislation and Advocacy.** The committee shall focus on topics including but not limited to keeping the RFS informed of legislative and regulatory issues as they relate to the training and future practice of Residents and Fellows, assisting in enhancing grassroots legislative efforts, encouraging resident and fellow participation and involvement in AMA Advocacy Conferences and AMPAC, and developing and implementing policies and directives of the Assembly that are related to legislation. Both the RFS member of the AMA Council on Legislation and the RFS member of the AMPAC Board of Directors shall serve as ex officio members of this committee.~~

~~3. **Committee on Long Range Planning.** The committee shall focus on topics including but not limited to studying and making recommendations on the Section's long range objectives, identifying and evaluating changes outside of the AMA that may impact residents and fellows in their future practice or training, and evaluating the implementation of the RFS Assembly policies and directives. The RFS member of the AMA Council on Long Range Planning and Development shall serve as an ex officio member of this committee.~~

~~4. **Committee on Medical Education.** The committee shall focus on topics including but not limited to evaluating current medical student and resident education, bringing forth ideas for improvements to the current medical and resident education system, and developing and implementing policies and directives of the Assembly that are related to medical education. The RFS member on the AMA Council on Medical Education shall serve as an ex officio member of this committee.~~

~~5. **Committee on Membership.** The committee shall focus on topics including but not limited to developing and evaluating strategies for member engagement, marketing, wellness, and retention within the RFS, and developing and implementing policies and directives of the Assembly that are related to membership.~~

~~6. **Committee on Public Health.** The committee shall focus on topics including but not limited to RFS positions on public health issues, grassroots programs for tackling public health issues, and developing and implementing policies and directives of the Assembly that are related to public health. The RFS member on the AMA Council on Science and Public Health shall serve as an ex officio member of this committee.~~

~~7. **Committee on Quality and Patient Safety.** The committee shall focus on topics including but limited to addressing issues of medical quality, quality improvement, and patient safety, developing a better understanding of the government agencies and regulatory bodies that govern quality measures and their implementation and utilization as it affects residents and fellows in their training and future practice, and developing and implementing policies and directives of the Assembly that are related to quality and patient safety.~~

~~8. **Committee on Scientific Research.** The committee shall focus on topics including but not limited to assisting the Vice Speaker in organizing, running, and selecting posters for the annual Research Symposium, assisting in the creation of RFS positions on scientific issues, and developing and implementing policies and directives of the Assembly that are related to scientific research. The RFS member on the AMA Council on Science and Public Health shall serve as an ex officio member of this committee.~~

~~9.~~ **F. Ad Hoc Committees.** The Governing Council may, at their discretion or when directed to do so by the RFS Assembly, create ad hoc committees. These are created for a specific purpose. Members of the committee and length of committee existence are determined by the Governing Council unless otherwise specified by directive from the RFS Assembly.

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~~**XII. Regions**~~

~~**A. Purpose.** The Regions shall exist to foster and promote RFS activities and membership on a regional and local level. The Regions shall function as a means of dissemination of RFS information, of recruitment to the RFS, and of opportunity for involvement and leadership for RFS members.~~

~~**B. Membership.** The Regions shall be delineated as below:~~

~~1. Region 1: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming.~~

~~2. Region 2: Illinois, Iowa, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Wisconsin.~~

~~3. Region 3: Arkansas, Kansas, Louisiana, Mississippi, Oklahoma, Texas.~~

~~4. Region 4: Alabama, Florida, Georgia, North Carolina, South Carolina, Tennessee.~~

~~5. Region 5: Indiana, Kentucky, Michigan, Ohio, West Virginia.~~

~~6. Region 6: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia.~~

~~7. Region 7: Connecticut, New York, Maine, New Hampshire, Massachusetts, New Jersey, Rhode Island, Vermont.~~

~~8. Region 8: National Specialty Societies, Military and Other Federal Agencies, all other societies not otherwise named herein.~~

~~9. Should any individual be a potential member of multiple regions due to educational, military, geographic and or specialty status, they must select their Regional affiliation at the time of the Business Meeting. No member~~

~~shall be a voting member for more than one region nor shall they be allowed to change their regional affiliation during a Business Meeting.~~

~~**C. Elections.** Elections shall be performed in accordance with IOP section V.I.4.~~

~~**D. Activities.**~~

~~1. During the Business Meeting. Regions shall be encouraged to caucus on items of business being discussed by the Assembly, candidates for election and endorsement, and issues of importance to the Region.~~

~~2. Between Business Meetings. Regions shall be encouraged to interface with local leaders within their Region with a focus on membership, RFS events, partnerships, and leadership opportunities.~~

~~**E. Regional Council.**~~

~~1. Purpose and Function. The Regional Council is designed to foster and promote strategic relationships between the RFS Governing Council, Regions, leaders of state and specialty society resident sections, and local residency and fellowship programs.~~

~~2. Membership. The Regional Council is comprised of eight Regional chairs and the Member At Large of the RFS Governing Council, who shall serve as chair of the Regional Council.~~

~~3. Meetings. The Regional Council shall meet at least quarterly either in-person or by teleconference in order to conduct the business of the Council.~~

~~4. Neutrality. During election of new Regional Council members, existing Regional Council members shall maintain the same neutrality standards expected of the Governing Council, as outlined in Section V.D.1.h.~~

~~XIII.~~XII. Miscellaneous

A. Parliamentary Authority. The parliamentary authority of the AMA House of Delegates governs this Section in all parliamentary situations that are not provided for in the law or in the AMA Bylaws or adopted rules of the RFS.

B. Amendments to the Internal Operating Procedures.

1. A proposal to modify these Internal Operating Procedures may be initiated through a resolution by any member of the Assembly, or by a report from the Governing Council or designated committee.
2. ~~–~~Acceptance of these changes requires the approval of two-thirds of the members of the Assembly present and voting.
~~1.~~3. ~~–~~Since changes to the RFS Internal Operating Procedures must be approved by the AMA Council on Constitution and Bylaws as well as the Board of Trustees, the RFS Governing Council shall notify the Assembly of any relevant changes made by ~~the AMA Board of Trustees~~these bodies.

C. Digest of Actions. A Digest of Actions is the compendium of official proceedings from the RFS Business Meetings and shall include directives for action to the RFS Governing Council and directives for advocacy by the RFS Delegate within the ~~HOD~~House of Delegates. An updated Digest shall be made available to RFS members following each ~~RFS~~ Business Meeting.

D. Endorsement of Candidates Not Otherwise Described Above. The ~~Resident and Fellows Section~~RFS does not endorse candidates for positions who are not currently RFS members ~~of the Resident and Fellow Section~~. However, RFS members may endorse candidates as individuals.

E. RFS Caucus in the House of Delegates.

1. The RFS Delegate and Alternate Delegate shall be responsible for leading the caucus consisting of all duly-elected and appointed RFS Sectional Delegates and Alternate Delegates. The role of the caucus shall be to enact the will of the Assembly in the HOD. Any RFS member is welcome to attend the RFS Caucus Meeting.

2. In cases where there is no existing position to guide action, the caucus may formally take a position with approval of a simple majority when a quorum is present. A quorum, in this instance, shall be defined as 50% + 1 of the caucus.

3. Internal votes taken by the RFS delegation shall guide the actions of the delegation for the meeting in question, but shall not be applicable to future meetings.

4. The RFS Delegate and Alternate Delegate shall draft a report within 30 days of the conclusion of each business meeting detailing the actions of the caucus, and any internal votes taken.

5. Should a vacancy arise within the caucus during the course of a meeting, the RFS Delegate and Alternate Delegate may appoint an RFS member to fill the vacancy for the duration of that meeting only.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: C
(A-24)

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Business and Economics

Subject: Financial Transparency of the Revenue Generated by Trainees at Health Systems

Referred to: Reference Committee

Introduction

At its 2023 Interim Meeting, the AMA-RFS Assembly considered the resolution "Financial Transparency of the Revenue Generated by Trainees at Health Systems," which stated the following:

> RESOLVED, that our AMA advocate for increased transparency of revenue generated for health systems by resident and fellow physicians; and it be further
>
> RESOLVED, that our AMA work with relevant stakeholders to require health systems to report revenue generated by care associated with resident and fellow physicians in the form of a publicly-accessible annual report.

Based on the Reference Committee Report, this was felt to be a complex issue needing further in-depth examination. The AMA-RFS Assembly voted to refer this resolution for additional study and this report was prepared accordingly by your RFS Committee on Business and Economics to present related evidence and recommendations as below.

Background

In the United States, Graduate Medical Education (GME) is funded through a multitude of sources, both private and public. The largest source of GME funding comes from the Federal Government, specifically through Medicare and Medicaid[1].

The largest source of federal funding for GME comes from Medicare. Due to the *Balanced Budget Act of 1997*, the number of residency spots funded by Medicare are limited[1].

There are two mechanisms by which Medicare provides GME funding, which are Direct GME (DGME) and Indirect GME (IME). DGME assists in paying "direct teaching costs" - for example, paying for resident and faculty salaries[2].

IME funding is more complex. It is linked to the amount of Medicare patients a hospital serves and to program size, and its payments allow for support of more specialized care for a teaching institution serving vulnerable populations. They also provide funding for indirect costs such as updated technology and additional support staff[2].

The second largest source of federal funding for GME comes from Medicaid, which varies by state. States may choose to include GME training costs as a component of overall hospital costs, which are then shared by matching costs through the federal government[1].

While it is the largest source, the federal government is not the only source of funding for GME programs[1,2]. Spots can also be funded through private entities - for example, the Transfusion Medicine Fellowship at University of California Los Angeles is funded through the Henry Brandler Endowment Fund[3].

Discussion

While it has been said that there is a lack of transparency surrounding GME funding and the value of trainee work[4], models and financial analyses have been made to assess this issue.

When replacing residents with other healthcare professionals, it has been shown that residents and fellows provide a lower cost in labor for the institution in comparison to non-trainee labor[5]. Additionally, it has also been found that residents provide a significant increase in RVU for an institution, with one report finding trainee workload in outpatient clinics covering at most 3.6-6.8 times the direct cost of the trainee[6].

Conclusion

Comparing the revenue of trainees to other healthcare professionals and measuring trainee productivity through RVUs has been studied previously in some specialties. Expanding these financial models to include each specialty for a multi-institutional survey is a feasible way to understand trainee impact on revenue generated by health systems.

Recommendation

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

1. That our American Medical Association (AMA) ask the Accreditation Council for Graduate Medical Education (ACGME) to conduct a multi-institutional study including all specialties comparing trainee pay and workload to the healthcare provider pay and workload that would be needed if trainees were not present at that institution and that ACGME publicly publish the findings of this study.

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AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: D
(A-24)

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Public Health

Subject: Traffic-related Death as a Public Health Crisis

Referred to: Reference Committee

Introduction

At A-23, our RFS Assembly considered Resolution 9, which proposed that our AMA recognize traffic-related death as a preventable public health crisis that disproportionately harms marginalized populations; recognize walking and cycling as healthy behaviors and as fundamental rights, especially for marginalized populations; recognize that vehicle speed and weight are modifiable risk factors for traffic-related deaths; and support evidence-based strategies to achieve zero traffic fatalities by 2050. Testimony on the Virtual Reference Committee expressed concerns about the novelty and actionability of the proposed policy, as well as whether this topic laid within the purview of AMA advocacy. Therefore, the Reference Committee recommended referral for study as well as reaffirmation of existing policy H-15.990 (Automobile Related Injuries). The RFS Governing Council therefore assigned this report to the RFS Committee on Public Health (CPH) for further study. In this report, we will examine the epidemiology of traffic-related injury and death, historical perspectives on the role of physician advocacy on traffic-related deaths, and current policy and design initiatives to reduce these deaths. We will then relate these findings to existing AMA policy to provide a recommendation to the RFS Assembly.

Background

Epidemiology of traffic-related injury and death

Until overtaken by firearm violence in 2017, motor vehicle crashes were the leading injury-related killer of American children, adolescents, and young adults aged 1-24 for 60 years.[1] Injuries sustained as a driver or passenger in a motor vehicle collision also account for the 3rd leading cause of nonfatal emergency department visits.[2] The Fatality Analysis Reporting System (FARS) is a nationwide census organized by the National Highway Traffic Safety Administration to estimate the yearly incidence and fatality of motor vehicle traffic crashes in the United States.[3] According to FARS, pedestrian deaths had been gradually decreasing since 1994, reaching a nadir of 4,019 in 2009; this figure has since continued to increase, with an estimated 7,388 pedestrians struck and killed in traffic incidents in 2021. A similar trend is observed for cyclists, with an estimated 966 cyclist fatalities in 2021 representing a substantial increase from 623 in 2010. Taken together, pedestrian and cyclist deaths are estimated to have made up 19.4% of all traffic-related deaths in 2021.

While this issue is not unique to the United States, there is a growing disparity between the U.S. and other high-income countries in which pedestrian and cyclist fatality rates have continued to fall, potentially explained by better walking and cycling infrastructure; lower urban speed limits; less total vehicle distance traveled; smaller and less powerful personal motor vehicles; and better education and enforcement of traffic regulations.[4]

The burden of traffic-related injury and death is not borne equally - BIPOC individuals, persons with disability, older adults, and pedestrians walking in lower-income neighborhoods face a statistically greater risk of being struck and killed in traffic incidents, which may be related to access to public and private transportation, inequity in infrastructure and the built environment, and even bias in interactions and signaling between drivers and pedestrians.[5-8] Furthermore, BIPOC individuals were more likely to experience a greater degree of impairment and to require a longer and more expensive hospitalization following their injury.[5] In 2000, the lifetime healthcare costs incurred from the sequelae of traffic crashes *in that year alone* was estimated to be as high as $40 billion.[7]

Historical role of physician advocacy on traffic-related injury and death

Historically, physician advocacy in the realm of motor vehicle transportation is not a new proposition and has contributed to significant improvement in the mortality and morbidity associated with the operation of motor vehicles.

As legal and public opinion battles raged around seat belt mandates and usage raged through the 1970s and 1980s, countless physicians voiced the impact on public health that such safety mechanisms could bring to bear. As head of the Rutherford County Health Department, pediatrician Dr. Robert Sanders[9] advocated for the Tennessee Child Passenger Protection Act mandating child safety seats until the first-in-the-nation law was passed in 1977. When the number of children injured or killed in car accidents in Tennessee dropped by half over the ensuing years, states around the country passed similar measures. Every state had passed child safety seat legislation by 1985, helping to prevent countless motor vehicle related tragedies over the years. In New York, orthopedic surgeon Dr. John States[10] leveraged his clinical experience, research, and position as chairman of the state medical society's committee on accident and injury prevention to help usher in the nation's first state law requiring drivers and all front-seat passengers to use seatbelts in 1984. The impact of these physicians' and others' advocacy for seat belts is clear, and the National Highway Traffic Safety Administration estimates that from 1975 through 2017, seat belts have saved an estimated 374,276 lives[11].

With the advent of handheld mobile phones, distracted driving became an increasing contributor to motor vehicle accidents. A landmark 1997 study[12] in the New England Journal of Medicine by Canadian internist Dr. Donald Redelmeier found that the risk of a collision while driving on the phone was four times higher than when not on the phone. This study and related advocacy led to New York passing the first law prohibiting all drivers from talking on a hand-held cellphone while driving in 2001. Since then, 34 states have adopted laws prohibiting hand-held phone use while driving and every state except Montana has adopted laws prohibiting texting while driving[13].

A perennial leading cause of traffic-related accidents, driving under the influence has been targeted by state legislations primarily led by citizen advocacy groups such as Mothers Against Drunk Driving. However, physician and public health advocacy has also contributed, as evidenced by the 1989 Surgeon General Workshop on Drunk Driving[14]. More recently, Dr. Redelmeier published a call to action for physicians to engage both in policy advocacy around driving under the influence and incorporate focused counseling into clinical encounters where applicable.

The AMA and state medical societies have also played a part in traffic safety advocacy. At the AMA 2016 Interim Meeting, the AMA House of Delegates adopted policy instructing the AMA to develop model state legislation to limit cell phone use to hands-free use only while driving. The AMA subsequently developed a model state bill[15] called the "Distracted Driving Reduction Act" that would prohibit the use of handheld mobile phones while driving and worked with state and national partners to encourage its adoption in states without distracted driving laws. The AMA

Code of Medical Ethics also offers an opinion on the physician's place in addressing medically impaired drivers, guiding clinicians in appropriate assessment of and response to medical conditions that may be high risk for impairing the safe operation of a vehicle.[16]

Contemporary efforts to address traffic-related injury and death

With recognition that the underlying causes of traffic incidents leading to injury and death are multifactorial, a diverse range of stakeholders have attempted to implement policy, educational, and design interventions to varying success. These stakeholders include but are not limited to municipal/state/federal policymakers, law enforcement, safety and inspection agencies, automobile manufacturers, public health experts, civil engineers, design psychologists, and community members. We list several of these past, current, and proposed policies and interventions aimed at addressing traffic-related injury and death:

Policy interventions

- A 2016 meta-analysis showed that increases in fixed penalties (e.g. fines) for traffic offenses are associated with fewer offenses as well as a reduction in accidents.[17]
- Pedestrian fatality is exponentially correlated with impact speed; thus, it may be unsurprising that speed limit reductions can reduce the rate of pedestrian motor vehicle collisions.[18,19]
- Installation of traffic cameras is correlated to a reduction in injuries and fatalities for all road users, including drivers, cyclists, motorcyclists, and pedestrians.[20,21]
- The implementation of distracted driving laws, typically targeting the use of cellphones while driving, has been associated with a lower incidence of motor vehicle fatalities.[22,23]
- Data is mixed regarding the role of traffic law enforcement in promoting safer driving and reducing pedestrian fatalities.[24-26]

Public outreach interventions

- Numerous year-long public outreach campaigns are hosted by the NHTSA, including National Distracted Driving Awareness Month in April, the Click it or Ticket National Seat Belt Campaign, and the Speeding Catches Up With You Campaign.[27-29]
- USDOT has launched a Call to Action campaign, inviting stakeholders to share how they are embracing the National Roadway Safety Strategy (NRSS) vision of eliminating roadway fatalities.[31]
- State DOT agencies frequently run focused versions of the public outreach campaigns above to meet local needs.

Automobile design interventions

- Compliant bumpers, dynamically raised hoods, and windshield airbags are built-in countermeasures that may reduce momentum transfer and subsequent injury in automobile-pedestrian collisions.[32]
- Electronic stability control systems improve vehicle stability and reduce loss of traction, and have been shown to lower risk of death for drivers, pedestrians, and bicyclists.[33]
- Although high costs and suboptimal operating conditions for pedestrian sensor technologies limit their current utility, rapidly evolving innovations in automated driving programs nevertheless show promise in mitigating pedestrian fatalities.[34]

Environmental design interventions

- Crosswalk visibility enhancements such as lighting, signing, pavement markings, and high-visibility crosswalks can reduce pedestrian-vehicle collisions by over 40%.[35]
- Medians and pedestrian refuge islands can reduce pedestrian crashes by 46-56%.[36]
- Separated bicycle lanes with flexible lane delimiter posts can reduce bicycle/vehicle accidents by 53%.[37]

- Rumble strips shown to reduce head-on crashes by up to 64% when placed at the center line and one-car off road crashes by up to 51% when placed at the shoulder of rural two lane roads.[38]

Discussion

To survey the AMA's existing policy on traffic-related death and injury prevention, we queried the AMA Policy Finder with the keywords "vehicle", "automobile", "pedestrian", "passenger", "bicycle", "bike", "driving", and "transportation" on March 19, 2024. Policies were screened for relevance and, if included, are reproduced in full below.

H-15.990 (Automobile-Related Injuries), which was recommended for reaffirmation in lieu of adopting RFS Resolution 9, comprehensively discusses motor vehicle injury and death as a public health crisis and clearly lists actionable areas for safety advocacy but does not focus on pedestrian or bicyclist safety nor the disproportionate impact of traffic-related death on marginalized groups. These former of these topics is instead addressed in policies H-10.964, H-15.952, H-15.960, H-139.989, H-470.952, and H-470.991, which collectively support improved safety, accessibility, and infrastructure for pedestrians and bicyclists on public roadways. In addition, H-15.952, H-15.960, H-15.962, H-15.970, H-15.982, H-15.986, H-15.992, H-15.993, H-15.999, H-30.936 provide further policy guidance toward automobile operator and passenger safety. Notably, D-15.992, H-15.962, H-15.990, and H-30.936 describe innovative technological and design approaches for driving injury prevention, including reference to autonomous vehicles, active and passive restraints, crash protection systems and devices, road and lighting design, and ignition interlock technology.

In considering the expansive scope of existing policy, we share the Reference Committee's judgment that Resolves 1, 2, and 4 of the original resolution may not substantively shift the direction or intensity of AMA advocacy to warrant creation of a new standalone policy. Furthermore, we suggest that the current language of H-15.970 - "to establish a reduction in highway injuries and deaths as a national goal" - is both sufficient and permissively broad to encompass the ask in Resolve 3. Specific endorsement of a numerical target or timeframe may be more expediently accomplished through existing AMA advocacy channels rather than creation of a new policy. There is a considerable effort at the federal level by the Department of Transportation to take a comprehensive approach in reducing traffic fatalities to zero and a call to action for allies with shared goals, including organizations such as the Centers for Disease Control and the National Association of Emergency Medical Technicians. This may serve as a future alternative opportunity for action already encompassed within current AMA policy to help actuate shared goals of improved traffic safety and reduced traffic-related fatalities.

Conclusion

In summary, your AMA-RFS Committee on Public Health considered three possible outcomes of this report: (1) adopting a resolved clause to propose an amendment to existing AMA policy, such as H-15.990; (2) updating internal RFS policy to strengthen our advocacy goals within traffic injury prevention if and when these topics are discussed at the HOD Assembly; or (3) recommending non-adoption. From our research, we noted several ideas that could be incorporated into future advocacy action by the AMA: to promote education for physicians and patients regarding modifiable risk factors for traffic-related injury and death; to support research into interventions to mitigate traffic-related injury and death among marginalized populations; or to publicly communicate support for such goals as stated in the Road to Zero resolution while also supporting adjuvant legislation, programs, and policies to achieve the objective of zero traffic fatalities or injuries by 2050. However, we recognize that existing policy would likely be broad enough to enable AMA advocacy staff to act on any state or federal initiatives addressed at these goals. To more effectively advocate on these goals within the House of Delegates, we propose adopting Resolution 9's resolved clauses as internal policy as well as formally endorsing several current

AMA policies related to traffic injury prevention and public health that are most directly relevant to the original aims of Resolution 9.

Recommendations

1. That that the referred resolved clauses from RFS Resolution 9-A-23 be amended as internal RFS position statements and adopted:

   RESOLVED, that our AMA-RFS recognize traffic-related death as a preventable public health crisis that disproportionately harms marginalized populations; and be it further

   RESOLVED, that our AMA-RFS recognize walking and cycling as healthy behaviors and as fundamental rights, especially for marginalized populations; and be it further

   RESOLVED, that our AMA-RFS support evidence-based strategies to achieve zero traffic fatalities; and be it further

   RESOLVED, that our AMA-RFS recognize that vehicle speed and vehicle weight are modifiable risk factors for traffic-related deaths; and be it further

2. That the following additional resolved clause be adopted:

   RESOLVED, that our AMA-RFS adopt AMA policies D-15.992, H-15.990, H-15.992, H-15.999, and H-470.991 as internal position statements in the Digest of Actions.

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RELEVANT RFS POSITION STATEMENTS:

410.018R Danger of Car Phones: That our AMA support further study into the dangers of the use of car phones and their impact on road traffic safety. (Substitute Resolution 20, A-97) (Reaffirmed Report C, I-07)

10.004R Impact of Speed Limits on Road Safety: That our AMA-RFS support the promotion of research and education regarding injury prevention and continue to assess the impact of increased vehicular speeds on overall road safety. (Substitute Resolution 28, A-95) [See also, AMA Policy H-15.990] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

RELEVANT AMA POLICY:

Evaluating Autonomous Vehicles as a Means to Reduce Motor Vehicle Accidents D-15.992
1. Our AMA will: (a) monitor the development of autonomous vehicles, with particular focus on the technology's impact on motor vehicle related injury and death; and (b) will promote driver, pedestrian, and general street and traffic safety as key priorities in the development of autonomous vehicles.
2. Our AMA will work with the National Transportation Safety Board to support physician input on research into the capability of autonomous or "self-driving" vehicles to enable individuals who are visually

impaired or developmentally disabled to benefit from autonomous vehicle technology. [Res. 407, A-19; Appended: Res. 427, A-19]

Helmets for Riders of Motorized and Non-motorized Cycles H-10.964
General Helmet Use: Our AMA: (1) encourages physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling; (2) encourages patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior; (3) encourages community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles; (4) urges manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety; (5) advocates further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use; (6) encourages efforts to investigate the impact of helmet use by riders of motorcycles and all bicycles, in order to establish the risk of major medical trauma from not wearing helmets, the costs added to the health care system by such behavior, and the payers of these added costs (i.e., private insurance, uncompensated care, Medicare, Medicaid, etc.); (7) supports the exploration of ways to ensure the wearing of helmets through the use of disincentives or incentives such as licensing fees, insurance premium adjustments and other payment possibilities. Bicycles: Our AMA: (1) actively supports bicycle helmet use and encourages physicians to educate their patients about the importance of bicycle helmet use; (2) encourages the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets; and (3) encourages the availability of helmets at the point of bicycle purchase. Scooters: Our AMA: (1) recommends the use of protective gear (certified helmets, elbow and knee pads, closed-toe shoes) for riders of scooters, especially children and adolescents; (2) encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures should be taken to prevent scooter injuries (e.g., riding away from traffic, and close supervision of riders under the age of eight); and (3) urges companies that manufacture or sell scooters to include appropriate information about the safe use of scooters on the scooters themselves, on or inside scooter packaging, on their web sites, and at the point of sale. Motorcycles: Our AMA: (1) encourages physicians to be aware of motorcycle risks and safety measures and to counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs; (2) endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (3) supports federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory motorcycle helmet laws by that state; (4) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (5) supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles. [CCB/CLRPD Rep. 3, A-14]

The Dangers of Distraction While Operating Hand-Held Devices H-15.952
1. Our AMA encourages physicians to educate their patients regarding the public health risks of distracted driving, which includes the risks of visual distraction – taking one's eyes off the road, manual distraction – taking one's hands off the wheel, and cognitive distraction – taking one's mind off what they are doing.
2. Our AMA will: (a) support legislation that would ban the use of hand-held devices while driving, as a step in the right direction towards preventing distracted driving and (b) encourage additional research to identify the most effective strategies to reduce distracted driving-related crash risks.
3. Our AMA: (a) recognizes distracted walking as a preventable hazard and encourages awareness of the hazard by physicians and the public; and (b) encourages research into the severity of distracted walking as a public health hazard as well as ways in which to prevent it.
4. Our AMA supports public education efforts regarding the dangers of distracted driving, particularly activities that take drivers' eyes off the road, and that the use of earbuds or headphones while driving is dangerous and illegal in some states.
5. Our AMA: (a) supports education on the use of earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking; and (b) supports the use of warning labels on the packaging of hand-held devices utilized with earbuds or headphones, indicating the dangers of using earbuds or headphones in both ears during outdoor activities requiring auditory attention, including but not limited to biking, jogging, rollerblading, skateboarding and walking.

6. Our AMA will make it a priority to create a national education and advocacy campaign on distracted driving in collaboration with interested stakeholders. [Res. 217, I-08; Appended: Res. 905, I-09; Appended: BOT Rep. 10, A-13; Appended: Res. 416, A-13; Modified in lieu of Res. 414, A-15; Appended: Res. 425, A-19; Appended: BOT Rep. 12, I-19; Modified: BOT Rep. 17, I-21]

Motor Vehicle and Bicycle Safety H-15.960
The AMA supports legislation that would make safety belt non-use by any occupants in automobiles and other enclosed motor vehicles a "primary offense" in all states; supports extension of motorcycle helmet laws to include motorized vehicles such as mopeds, scooters and all-terrain vehicles, and to cover all age groups; and supports legislation that would require helmet usage for riders of bicycles, including passengers. [Res. 226, A-95; Reaffirmed: BOT Rep. 12, A-05; Reaffirmed: CSAPH Rep. 1, A-15]

Air Bags and Preventing Crash Injuries H-15.962
Our AMA (1) encourages the U.S. Department of Transportation to expand efforts to determine the efficacy of air bags in preventing serious injuries and the efficacy and safety of the air bag combined with the lap-shoulder belt in preventing such injuries; (2) encourages motor vehicle manufacturers to continue efforts to improve the safety of vehicles, focusing especially on active and passive restraints and strengthening passenger compartments; and (3) encourages physicians to take an active role in encouraging the use of automobile active and passive restraints among the general public, including infants and children. [BOT Rep. H, I-92; Reaffirmation I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Trucks and Highway Safety H-15.970
The AMA (1) reaffirms its recommendation in Report I (I-82) to establish a reduction in highway injuries and deaths as a national goal; special attention should be given to this goal by the governmental, business, engineering, legal, and medical sectors; (2) urges vehicle manufacturers to improve the safety of trucks and truck cabs; (3) supports the strict standards on drug and alcohol use set in the Omnibus Transportation Employee Testing Act, requiring DOT agencies to implement drug and alcohol testing of safety-sensitive transportation employees; and (4) encourages regulators and truck fleet supervisors to give greater attention to drivers' performances and crash records, and to remove drivers with poor records from the highway. [BOT Rep. KK, I-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20]

Mandatory Seat Belt Utilization Laws H-15.982
Our AMA (1) supports mandatory seat belt utilization laws which do not simultaneously relieve automobile manufacturers of their responsibility to install passive restraints; (2) favors informing state medical societies about the status of mandatory seat belt utilization laws which simultaneously relieve automobile manufacturers of their responsibility to install passive restraints; (3) urges reconsideration of the administrative regulation of the U.S. Department of Transportation that would release automobile manufacturers from the responsibility of providing passive restraints when mandatory seat belt utilization for two-thirds of the U.S. population is attained; and (4) supports the amendment of state seat belt laws which contain exemptions for emergency medical services personnel, such that these laws would provide exemptions only when personnel are actively involved in patient care. [Sub. Res. 133, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CSA Rep. 8, A-05; Appended: Res. 909, I-10; Reaffirmed: CSAPH Rep. 01, A-20]

Automatic (i.e., Passive) Restraints to Prevent Injuries and Deaths from Motor Vehicle Accidents H-15.986
The AMA (1) supports legislation to promote availability of effective seat belts in school buses in the U.S.; and (2) supports legislative action to promote availability of effective seat belts in all motor vehicles in public use (e.g., public and private buses, taxicabs, and any other vehicles carrying passengers). [Sub. Res. 2, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmation A-04; Reaffirmed: BOT Rep. 29, A-04; Modified: CSAPH Rep. 1, A-14]

Automobile-Related Injuries H-15.990
Our AMA: (1) Encourages physicians to increase their awareness of the still largely overlooked problem of motor vehicle-related injuries and to discuss with their patients how they can avoid or prevent such injuries. (2) Calls for the establishment of a reduction in motor vehicle injuries as a national goal.
(3) Reaffirms its support for the development of effective passive crash protection systems for occupants

of motor vehicles. (4) Strongly endorses and encourages the use of active restraints, such as lapbelts, lapbelt-shoulder harnesses, and those that are approved for children. (5) Encourages motor vehicle manufacturers to develop automobiles with stronger passenger compartments that would more effectively protect occupants, and with interiors having fewer protuberant objects and hard surfaces that could cause injuries in crashes. (6) Continues to support state and federal legislative efforts to strengthen drunk driving laws and their enforcement. (7) Encourages national and federal organizations, such as the National Institutes of Health, the National Highway Transportation Safety Agency, and the National Science Foundation, and appropriate private groups, to devote more of their resources to research concerning vehicle-related injuries and their prevention. (8) Urges states to review their standards for the construction and maintenance of roads and highways. The standards should be based on current engineering knowledge and good practice, particularly as related to use of skid-resistant surfaces; shoulder grading; drivers' lines of vision; removal of obstructions; and separation of opposing traffic streams. (9) Encourages state and local officials to monitor streets, roads, and highways to identify sites with disproportionate risks of crashes, in order to take appropriate remedial actions. (10) Encourages continued study of the effect of increasing the legal age at which young persons may drink alcoholic beverages and supports increased study of behavioral factors in crashes, such as those relating to education, training and driving experience; school, family and work problems; aggression; depression and personality disorders; use of drugs; and criminal behavior. (11) Believes that, before the adoption of passive crash protection systems and devices to reduce motor vehicle injuries, industry and government demonstrate through field studies that such systems and devices are effective, safe, cost-effective and acceptable to drivers. (12) Supports the use of legal and constitutional sobriety checkpoints to deter driving following alcohol consumption. (13) Will work with interested state medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints. (14) Our AMA will encourage the National Highway Traffic Safety Administration to undertake the necessary rulemaking to integrate automated high-beam to low-beam headlight switching lamps into the Federal Motor Vehicle Safety Standards. (15) Our AMA will support more comprehensive Graduated Driver Licensing programs including but not limited to more stringent permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions. [CSA Rep. I, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-12; Appended: Res. 202, I-14; Reaffirmation A-15; Appended: Res. 401, A-18; Appended: Res. 426, A-18]

Motor Vehicle Accidents H-15.992
Our AMA (1) recognizes motor vehicle-related trauma as a major public health problem, the resolution of which requires a leadership role by physicians in concert with safety experts; and (2) strongly encourages other medical and health care organizations, as well as departments of health and transportation, to endorse the concept of motor vehicle related trauma as a public health problem, thereby lending its treatment to traditional public health measures. [BOT Rep. LL, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Child Passenger Safety H-15.993
Our AMA (1) urges all physicians and health care professionals to consider ways to encourage the protection of children in motor vehicles through the use of appropriate child passenger restraining devices and safety belts and (2) endorses and supports the efforts of other appropriate organizations to motivate and assist physicians and health care professionals and hospitals to inform parents of the importance of protecting children in motor vehicles with appropriate restraining systems. [Res. 27, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmation and Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Automobile Safety Standards H-15.999
The AMA supports proper legislation to establish safety standards for automobiles and will continue to offer to government, industry, and other interested parties its advice and consultation on the medical aspects of automotive safety. [Sub. Res. 36, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: CSAPH Rep. 01, A-19]

Prevention of Impaired Driving H-30.936
Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks; (2) supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; and (3) supports 21 as the legal drinking age, strong penalties for

providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21. Education: Our AMA: (1) favors public information and education against any drinking by drivers; (2) supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (3) encourages physicians to participate in educating patients and the public about the hazards of chemically impaired driving; (4) urges public education messages that now use the phrase "drunk driving," or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that "all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;" (5) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents; and (6) supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will continue to work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve those goals. Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver's license for one year and (b) for the second offense - mandatory revocation of the driver's license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; (3) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those who are identified with substance use disorder being strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities. Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life; Repeat Offenders: Our AMA: (1) recommends the following measures be taken to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) stronger penalties be leveled against repeat offenders, including second-time offenders, (c) such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses; and (2) calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third. On-board devices: Our AMA: (1) supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems; (2) encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and safe; and (3) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members. [CCB/CLRPD Rep. 3, A-14]

Green Initiatives and the Health Care Community H-135.939
Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource

utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. [CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18; Modified: Res. 923, I-19]

Government to Support Community Exercise Venues H-470.952
Our AMA encourages: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. [CSAPH Rep. 1, A-22]

Promotion of Exercise H-470.991
1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest.
2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible. [Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Excerpt from A-23 Reference Committee Report

(11) RESOLUTION 9 – TRAFFIC-RELATED DEATH AS A PUBLIC HEALTH CRISIS

RECOMMENDATION A:

Resolution 9 be referred.

RECOMMENDATION B:

The following HOD Policy be reaffirmed: H-15.990, "Automobile Related Injuries."

RESOLVED, That our AMA recognize traffic-related death as a preventable public health crisis that disproportionately harms marginalized populations; and be it further

RESOLVED, That Our AMA recognize walking and cycling as healthy behaviors and walking and cycling safety as fundamental rights, especially for marginalized populations; and be it further

RESOLVED, That Our AMA support evidence-based strategies to achieve zero traffic fatalities by 2050; and be it further

RESOLVED, That Our AMA recognize that vehicle speed and weight are modifiable risk factors for traffic-related deaths.

Your Reference Committee heard considerable testimony on this resolution, mostly in opposition as written. Concerns included the fact that the AMA already has robust policy on addressing motor vehicle collisions and that the resolution contains unattainable asks that may be outside the AMA's purview. The author provided testimony in response, suggesting amendments to resolve clauses 1-3 and eliminating the fourth resolve. While your Reference Committee agrees that the issue of minimizing disparities regarding traffic-related incidents, especially for marginalized populations, is a valuable one, we feel that the overall resolution as it stands or with the amendments proposed does not go far enough to enact meaningful change and thus is not ripe for advocacy. Therefore, your Reference Committee recommends Resolution 9 be referred and policy H-15.990 be reaffirmed.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: E
(A-24)

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Legislation and Advocacy (COLA)

Subject: Inclusion of All Passed Resolutions in the RFS Digest of Actions: Ten-Year Lookback

Referred to: Reference Committee

Background

At the 2023 Annual Meeting, the AMA-RFS Assembly adopted amended Resolution 12, "Inclusion of All Passed Resolutions in the RFS Digest of Actions." The impetus for this resolution was the lack of a specified process for including or removing resolutions written with an external ask (that is, resolutions adopted by the AMA-RFS Assembly to be sent by the AMA-RFS Delegation to the House of Delegates) in the RFS Digest of Actions. Under the current system, policies sent to the House by the RFS were sometimes subsequently removed from the policy digest, leaving the RFS without a position on an issue upon which it had voted as an Assembly to take a position.

As adopted, I-23's Resolution 12 called on the RFS to perform a ten-year lookback review of all external policies adopted by the Section and subsequently never added to the Digest when the resolution was sent to the House to reconcile it with our internal policy digest. This resolution clarified that in the future, all resolutions written as external resolutions would also become internal policy of the RFS and should be added to our RFS Digest of Actions. The spirit of the resolution was to expand the internal digest to more accurately reflect the intent of the RFS as voted upon in the RFS Assembly and to provide improved voting directives in the House of Delegates. This would, in theory, decrease the need for caucus votes on items at the House of Delegates meeting since there would be an expanded compendium of positions which the AMA-RFS adopted to draw upon. This change in processes would also maintain the original wording of language adopted by the RFS even if the language changes at the House of Delegates after RFS submission.

Your Committee on Legislation and Advocacy systematically reviewed the Summary of Actions and Delegate Reports of every meeting from Annual 2013 to Annual 2023. Your Committee reviewed each internal and external policy and reconciled with the existing RFS Digest of Actions. For simplicity, your Committee only included items in this report which were (1) adopted or (2) adopted as amended. We did not include items that were (1) referred, (2) called for a study (i.e., "The AMA-RFS study…), or (3) not adopted as these items should not have been included in the Digest in their form at the time. We also did not include informational or Sunset Reports.

Recommendations for each removed policy fall into three categories: 1) Add to the RFS Digest; 2) Take no action; or 3) Recommend reconciliation. Generally speaking, policies with the first recommendation are those that the RFS Assembly clearly passed and then forwarded to the HOD or, in other words, sought to generate policy external to the RFS. Those with no action recommended are generally those that are currently already found in the RFS Digest of Actions

or similarly require no intervention, given the nature of the policy. Those your Committee requests reconciliation for will require more attention by the RFS Governing Council to discern the appropriate action. Examples of these resolutions/reports are those that appear to have not been forwarded but are not in the Digest of Actions, those whose recommendation depends on information to which this Committee does not have access at this time or are otherwise difficult to reconcile with current policy given subsequent or complex changes. Mechanisms by which positions may have changed by the present day since passage include Sunsetting, subsequently adopted policies that supersede previous policies, actions by the Assembly to amend a policy or strike a policy from the digest, etc.

Discussion

Moving forward, all internal and external policies adopted by the AMA-RFS Assembly will be added to the Digest of Actions. As a note, the text that was adopted at the RFS Assembly will be placed in the Digest for external resolutions. However, it should be noted that when a resolution is sent to the House of Delegates, it may be amended by the House so that the final form of the resolution present in the AMA policy compendium may differ from that adopted by the AMA-RFS.

This information is presented to the Assembly at this Annual 2024 Meeting as a report. If a delegate disagrees with the recommendation, that delegate may extract individual Recommendations for individual policies without extracting the entire report. A tabular summary of the review is found in Appendix A.

Recommendations

1. That our AMA-RFS will retain all policies that are adopted by the RFS Assembly, whether external or internal, in the RFS Digest of Actions, until they are removed by active rescission or sunset or altered by amendment.
2. That our AMA-RFS will modify our current Digest of Actions to add previously passed policy as per the “Recommendations” Column in Appendix A.
3. That our AMA-RFS Governing Council will reconcile those policies by which more attention is needed to determine appropriate placement per the “Recommendations” Column in Appendix A of this report.
4. That our AMA-RFS Governing council will produce a report which details how the added and reconciled policies were combined with the current Digest of Actions.

APPENDIX A - RECOMMENDED ACTIONS ON PREVIOUSLY ADOPTED POLICIES

Resolution	Text	Recommendation
Annual 2013		
Late Resolution 1 - Addressing the Physician Workforce Shortage by Increasing GME Funding	RESOLVED, that our AMA-RFS~~,~~ work with the AMA and in ~~with~~ consultation with ~~of~~ 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 be it further RESOLVED, that our AMA-RFS work with the AMA to support pilot projects supported through state and federal funding in medically under-served areas that foster resident training programs, offer loan repayment, and support independent practice development as a means to address the physician workforce shortage.	No action; already in Digest.
Resolution 2 – Simulation: An Educational Tool for Training and Skill Maintenance	RESOLVED, that our AMA-RFS encourage medical schools and teaching hospitals to incorporate simulation as an educational tool and develop ways in which it could become a method of evaluating medical student/physician performance.	No action; already in Digest.
Resolution 3 – Transparency on Maternity and Paternity Leave Policies for Trainees	RESOLVED, that our AMA encourages all medical education and training programs ~~facilities~~ to make maternity, ~~and~~ paternity, and adoption ~~and family and medical~~ leave policies transparent and readily available to any applicant in a manner which unequivocally states if and how leave may be taken for these events without incurring extension of training. ~~removes fear of prejudice for having requested that information. Graduate medical training programs should create an anonymous means of obtaining that information, whether it be available in writing or online, to all applicants for a training program; and be it further~~ ~~RESOLVED, that this resolution be immediately forwarded for consideration during the 2013 Annual meeting of the AMA House of Delegates.~~ Amended by change in title to read: TRANSPARENCY ON MATERNITY, PATERNITY, AND ADOPTION LEAVE POLICIES FOR TRAINEES	No action; already in Digest.
Resolution 4 – Graduate Medical Education Funding and Quality of Resident Education	RESOLVED, that our AMA explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the ACGME.	No action; already in Digest.
Emergency Resolution 1 - Policy-making meetings for MSS and RFS	RESOLVED, that our AMA-RFS support one policy making meeting per year for the AMA-HOD.	No action; already in Digest.

Late Report H – AMA-RFS 2013-2016 Working Plan	V. RECOMMENDATIONS In the Realm of **National Meetings** 1. The RFS Governing Council should work with the AMA to encourage RFS participation ~~in a second business meeting to occur after the annual~~ between meetings and that; a. The RFS should continue to work to ensure that the MSS/RFS research poster symposia continues to be held at a national meeting; b. The RFS Governing Council will continue to work with staff to increase resident and fellow attendance at leadership training events, including the National Advocacy Conference and AMA leadership retreats 2. The RFS Governing Council should continue to improve the process of election procedures to ensure adequacy, transparency and integrity of the results; 3. The RFS Governing Council should continue to work to improve content at national meetings that will be relevant to members and that will engage them in the core areas of AMA involvement, Advocacy, Public Health, Community Service, Legislative Policy, Leadership Development and Membership; In the realm of **Advocacy** that; 4. The RFS should continue to make preserving and improving GME funding and addressing future physician workforce issues a key priority of our advocacy actions; 5. The RFS Governing Council should continue to annually identify key issues and mobilize the grassroots network to involve our section in advocating for RFS friendly positions on said issues and continue to educate the general assembly on these issues; 6. That the RFS should continue to work with other resident and fellow based organizations to ensure that the RFS serve as the national spokesperson for all resident and fellow centered issues including student debt, graduate medical education, medical licensure, and resident work hours. In the realm of **Membership and Outreach**; 7. The RFS and RFS Governing Council should investigate mechanisms to increase retention of members as they transition from one section to another including; a. Members transitioning from MSS to RFS; b. Members transitioning from the RFS to the YPS; c. Members transitioning out of IPM programs; 8. The RFS should continue to work with the MSS and the YPS to improve mentoring strategies and increase mentoring opportunities such as combined	No action; generated a report.

networking events, mentoring panels, combined working groups and specific events targeted by specialty, year or location;

9. The RFS should continue to examine and improve the role of the regions within the RFS, which should include:
    a. Current contact information for region leadership and their contact information available online for access by members;
    b. The current level of activity in each region and ways to increase involvement;
    c. The roles and responsibilities of the region leadership;
    d. Novel ways to improve communication, foster leadership and increase membership;
    e. Collaboration with MSS and YPS Sections, including joint region meetings and community service events;
10. The RFS Governing Council should work to establish local membership liaisons that will work directly with GME programs to reach out to residency programs and recruit members;
11. The RFS should continue to work with AMA membership staff to assist with planning local membership recruitment programs and coordinate the involvement of local RFS leaders in said programs;
12. RFS leaders should continue to encourage Section participants to introduce the Introduction of the Practice of Medicine program to their relevant academic and medical center faculty.

In the realm of **Communication:**

13. The RFS and RFS Governing Council should work to establish online social media portals to encourage involvement in RFS activities and increase RFS awareness;
14. The RFS Governing Council should investigate methods to ensure there is effective communication with the region leadership on a regular basis;
15. The -RFS Governing Council should establish a mechanism to provide Governing Council updates and direct communication to our membership and work with AMA staff to ensure that these updates be disseminated to all RFS members;
16. The RFS Governing Council should actively work to increase utilization of the RFS list-serve and make it available to new members;

Lastly, in general the Committee recommends that:

17. The RFS recommend that a Working Plan be developed by the Committee on Long Range Planning for the RFS Governing Council and approved by the assembly at least every 3 years.

Report G – Comprehensive Access to Safety Data from Clinical Trials	RESOLVED, That our AMA urge the Federal Drug Administration to investigate and develop means by which academic investigators can access original source safety data from industry-sponsored trials upon request; and be it further RESOLVED, That our AMA support the adoption of universal policy by medical journals requiring principal investigators to have independent access to all study data from industry-sponsored trials.	No action; generated a report.
Interim 2013		
Emergency Resolution 1: AMA-HOD Resolution 819 (I-13) on "Health Insurance Carriers Canceling Coverage for Hundreds of Thousands of Patient Across the Country"	~~RESOLVED, that our AMA-RFS encourage our American Medical Association to work with the President, legislators, and the Centers for Medicare and Medicaid Services, so that *individual subscribers to health insurance plans that were not in compliance with Affordable Care Act standards, and who therefore experienced cancellations of their health insurance*, be able to renew or otherwise extend their existing insurance contracts until such time that affordable and comparable replacements are available through the Exchanges or within the private market. (Directive to Take Action)~~ RESOLVED, that our AMA-RFS support President Obama's plan to allow individual subscribers to health insurance plans that were not in compliance with the Affordable Care Act (ACA), and who therefore experienced cancellations of their health insurance, be able to renew their recently-cancelled insurance contracts for one year; and be it further RESOLVED, that our AMA-RFS work with other interested stakeholders to delay penalties for non-insurance under the Affordable Care Act (ACA) for one year and extend the deadline to enroll for insurance under the ACA for one year, only for those who experienced cancellations of their individual health insurance due to noncompliance with the ACA; and be it further RESOLVED, that our AMA-RFS work with other interested stakeholders to help implement fixes to the Affordable Care Act that will help individual subscribers to health insurance plans that were not in compliance with the Affordable Care Act (ACA), and who therefore experienced cancellations of their health insurance	Add to Digest.
Late Resolution 3: Exemption of Fellows from Requirements of Physician Payment Sunshine Act	Resolved, that our AMA advocate in conjunction with appropriate stakeholders, that the CMS use our AMA definition of Resident when formulating rules and regulations. ~~Resolved, that our AMA work in conjunction with all appropriate state and specialty societies to conduct a study to determine the impact of the Physician Payment Sunshine Act on Fellows, as defined by CMS, and be it further~~ ~~Resolved, that our AMA develop recommendations regarding further action to clarify the status of Fellows and prevent inappropriate or unanticipated reporting under the requirements of the Physician Payment Sunshine Act, with a report back at A-14, and be it further~~	No action; already in Digest.

	Resolved, that this resolution be immediately forwarded for consideration during the 2013 Interim Meeting of the AMA House of Delegates.	
Resolution 1: Providing Residency Applicants a Timely Response to Residency Application Outcome	~~RESOLVED, that our AMA encourage the AAMC and ACGME to propose a standardized timeframe for residency programs to provide a timely response of rejection to residency applicants.~~ RESOLVED, that HOD policy H-310.998 Residency Interview Schedules be amended by addition and deletion as below: The AMA encourages ~~accredited~~ residency and fellowship programs to incorporate in their ~~residency~~ interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. The AMA encourages the ACGME and other accrediting bodies to require ~~residency~~ 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. ~~about their interview status and provide a time frame of notification dates in the application materials.~~ (Res. 93, I-79; Reaffirmed: CLRPD Rep. B, I-89; Appended: Res. 302 and Res. 313, I-97; Reaffirmed: CME Rep. 2, A-07)	No action; already in Digest.
Late Report F: Protecting Residents Against Avoidable Financial Constraint Related to Reimbursed Work-Related Expenses	Resolved, that our AMA promote 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. Resolved, that our AMA encourage a system of expedited repayment for purchases of $200 or less, for example through payment directly from their programs (in contrast to following traditional workflow for reimbursement). Resolved, that our AMA encourage 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 is strongly recommended in advance but at a minimum, reimbursement should be completed at 2 weeks and not to exceed 1 month after submission of relevant reimbursement documents; and *Unplanned expenses* which includes money spent collectively above the planned amount by trainees is strongly recommended to be reimbursed by 1 month after submission of relevant reimbursement documents, with a period not to exceed 6 weeks.	No action; already in Digest.

	Resolved, that this report and its recommendations as adopted by our Assembly be transmitted to GME programs nationwide.	
Report E: Amending the ACGME Residency Due Process Requirements	That our ~~American Medical Association~~ AMA-RFS advocate for the amendment of the ACGME's Institutional Requirements to specifically require that institutional grievance policies governing the dismissal or non-renewal of a resident or fellow include the following principles, in writing:	No action; already in Digest.
Resolution 1—Resident and Fellow Work-Life Balance	RESOLVED, That our AMA advocate for resident and fellow trainees to be regularly given separately allotted protected time dedicated for mental health, rather than the current practice of sharing "personal days" with illness, other health-related appointments, family emergencies, and interviews; so that trainees can participate in elective stigma-free mental health and substance use disorder services, in order to maximize work-life balance; and be it further RESOLVED, That our AMA support governing bodies, including ACGME, in developing and expanding on formal policy and standards aimed at protecting resident and fellow trainees' well-being, including professionally, physically, psychologically, and socially, during the course of their training.	No action; generated a report.
Resolution 2 Denouncing Racial Essentialism in Medicine	RESOLVED, That out AMA-RFS recognizes that race is a social construct rather than an inherent biological or genetic trait, and their false conflation can lead to inadequate examination of true underlying risk factors; and be further RESOLVED, That our AMA-RFS recognizes that structural racism exists in the American healthcare system and that it is a systemic and public health crisis; and be it further RESOLVED, That our AMA-RFS acknowledge that there may be inherent biologic and genetic traits, distinct from race, linked to certain diseases and that these should be studied and appropriately factored into risk algorithms, screening, and treatment; and be it further RESOLVED, That out AMA-RFS encourages appropriate stakeholders to eliminate racial essentialism from clinical algorithms in an evidence-based fashion; and be it further RESOLVED, That our AMA-RFS encourages appropriate stakeholders to eliminate racial essentialism in medical education curricula and board examinations.	No action; already in Digest.
Resolution 3—Availability of Personal Protective Equipment (PPE)	RESOLVED, That our American Medical Association advocate that it is the responsibility of healthcare facilities to provide sufficient personal protective equipment (PPE) for all employees and staff in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need (Directive to Take Action); and be it further RESOLVED, That our AMA support minimum evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions (New HOD Policy); and be it further	No action; already in Digest.

	RESOLVED, That our AMA advocate that physicians and healthcare professionals must be permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided PPE without penalty (Directive to Take Action); and be it further RESOLVED, That our AMA affirm that the medical staff of each health care institution should be meaningfully involved in disaster planning, strategy and tactical management of ongoing crises (New HOD Policy); and be it further RESOLVED, That our AMA work with The Joint Commission, the American Nurses Credentialing Center, the Center for Medicare and Medicaid Services, and other regulatory and certifying bodies to ensure that credentialing processes for healthcare facilities include consideration of adequacy of PPE stores on hand as well as processes for rapid acquisition of additional PPE in the event of a pandemic (Directive to Take Action); and be it further RESOLVED, That our AMA study a physician's ethical duty to serve in a pandemic including but not limited to the following considerations: 1. The availability and adequacy of institution-supplied PPE and whether inadequate PPE modifies a physician's duty to act; 2. Whether a physician's duty to act is modified by the personal health of the physician and/or those with whom the physician has regular extended contact; 3. Whether a physician's duty to their personal and population safety allows them to speak with local and national media about the safety of their work environment as it relates to the risk it places on themselves, their immediate family and regular social contacts, and the public at large; 4. How medical students, residents, and fellows are affected in the setting of a pandemic in terms of their ethical obligation to care for patients, ramifications to their education, and the protections necessary given their vulnerable status; and 5. The ethical obligation of healthcare institutions and the federal government to protect the physical and emotional wellbeing of physicians and other healthcare workers during and after a pandemic. (Directive to Take Action)	

Resolution 4—Support for Safe and Equitable Access to Voting	RESOLVED, That our AMA support measures to facilitate safe and equitable access to voting ~~reduce crowding at polling locations~~ as a harm-reduction strategy ~~and facilitate equitable access to voting as a means~~ to safeguard public health and mitigate unnecessary risk ~~to immunocompromised groups, including:~~ of infectious disease transmission~~;~~ by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improve access to drop off locations for mail-in or early ballots; and be it further ~~(g) stipulating that ballots postmarked by Election Day must be counted; and be it further~~ RESOLVED, That our AMA oppose requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail; and be it further RESOLVED, That this resolution be immediately forwarded to the November 2020 House of Delegates Special Meeting.	Add to Digest.
Report F—Physician Autonomy Resolution 6—Non-Physician Post-Graduate Medical Training	RESOLVED, That our AMA support pay equity among trainees within the healthcare team and believes that salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence allowed by an individual's training program; and be it further RESOLVED, That our AMA amend policy H-275.925 "Protection of the Titles "Doctor," "Resident" and "Residency" by addition and deletion to read as follows: Our AMA: (1) recognize that the terms "medical student," "resident," "residency," "fellow," "fellowship," "doctor," and "attending," when used in the healthcare setting, all connote completing structured, rigorous, medical education undertaken by physicians, thus these terms should be reserved to describe physician role; ~~(1)~~ (2) ~~will~~ advocate that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained and develop model state legislation for implementation; and ~~(2)~~ (3) support~~s~~ state legislation that would penalize misrepresentation of one's role in the physician-led healthcare team, up to and including to make it a felony to misrepresent oneself as a physician (MD/DO)~~.~~; and (4) support state legislation that calls for statutory restrictions for non-physician post-graduate diagnostic and clinical training	R1, R5, R6, R7, R8: Add to Digest. R2, R3, R7: No action; would not affect internal policy. R4: No action; asking for report.

	programs using the terms “medical student,” “resident,” “residency,” “fellow,” “fellowship,” “doctor,” or “attending” in a healthcare setting.; and be it further RESOLVED, That our AMA amend policy H-160.949, “Practicing Medicine by Non-Physicians” by addition to read as follows: …(7) support Nurse Practitioners and Physician Assistants pursuing postgraduate clinical training prior to working within a subspecialty field.; and be it further RESOLVED, That our AMA study curriculum and accreditation requirements for graduate and postgraduate clinical training programs for non-physicians and report back at A-22 and biennially thereafter, on these standards, their accreditation bodies, their supervising boards, and the impact of non-physician graduate clinical education on physician graduate medical education; and be it further RESOLVED, That our AMA work with relevant stakeholders to assure that funds to support the expansion of post-graduate clinical training for non-physicians do not divert funding from physician GME; and be it further RESOLVED, That our AMA partner with the ACGME to create standards requiring Program Directors and Designated Institutional Officials to notify the ACGME of proposed training programs for physicians or non-physicians that may impact the educational experience of trainees in currently approved residencies and fellowships; and be it further RESOLVED, That policy H-310.912 “Resident and Fellow Bill of Rights” be amended by addition and deletion to read as follows: …B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows ~~should expect supervision by physicians and non-physicians~~ must be ultimately supervised by 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 requirement for supervision of residents.~~ In instances where education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution, or ACGME as appropriate.; and be it further	

	RESOLVED, That our AMA will distribute and promote the *Residents and Fellows' Bill of Rights* online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles; and be it further RESOLVED, That our AMA oppose non-physician healthcare providers from holding a seat on medical boards that provide oversight of physician undergraduate medical education, graduate medical education, certification or licensure, and advocate that a non-physician seat on these boards be held by non-medical public professionals. RESOLVED, That this resolution be immediately forwarded for consideration at the November 2020 Special Meeting of the House of Delegates.	
Annual 2014		
Late Resolution 1: Protecting the Right of a Residency Trained Physician to Practice Medicine Within His/Her Scope of Practice and Maintain Board Certification While Doing So	Derived from Digest of Actions rather than Annual Digest of Actions: RESOLVED, that our AMA-RFS oppose the establishment of scope of practice limitations through use of board certifications by the American Board of Medical Specialties and its member organizations.	No action; already in Digest.
Resolution 2: Facilitating Resident Transfers In and Out of Residency Programs	RESOLVED, That our AMA-RFS study the issue of resident transfers between programs to better identify the scope of this issue.	No action; generated a report.
Resolution 3: Environmental Toxins and Reproductive Health	RESOLVED, that our AMA-RFS support rigorous scientific investigation into the causes and prevention of birth defects; and be it further RESOLVED, that our AMA-RFS support rigorous scientific investigation into the linkages between environmental hazards and adverse reproductive and developmental health outcomes; and be it further RESOLVED, that our AMA-RFS support policies to identify and reduce exposure to environmental toxic agents; and be it further RESOLVED, that our AMA-RFS support policies to address the consequences of exposure to environmental toxic agents, including the reporting of identified environmental hazards to appropriate agencies; and be it further RESOLVED, that our AMA-RFS encourage physicians to learn about toxic environmental agents common in their community and educate patients on how to avoid toxic environmental agents; and be it further RESOLVED, that our AMA-RFS support policies and practices that support a healthy food system. ~~; and be it further~~	No action; already in Digest.

	~~RESOLVED, that our AMA reaffirm its policy H-150.947, to encourage pregnant and breastfeeding women, as well as women in the preconception period, to eat carefully washed fruits and vegetables and to avoid fish containing high levels of methyl mercury (such as shark, swordfish, king mackerel, and tilefish).~~	
Resolution 4: AMA Participation in Medical Student Debt	RESOLVED, that our ~~American Medical Association explore the feasibility~~ AMA-RFS support the exploration of the development of an affinity program in which student, resident and fellow members of the AMA could consolidate existing educational loans or obtain new educational loans from one or multiple national banks or other financial intermediaries. ~~Membership in the AMA would be required during the life of the loan (typically 10 years or more following medical school), and such activitie4s or program would neither result in the AMA becoming subject to regulation as a financial institution nor impair the AMA's ability to continue to be treated as a not-for-profit entity; and be it further~~ ~~RESOLVED, that our AMA HOD receive a progress report on these discussions by the 2014 Interim Meeting (Directive to Take Action); and be it further~~ ~~RESOLVED, that this resolution be immediately forwarded to the AMA at A-14.~~	No action; already in Digest.
Resolution 5: Insurance Coverage for Fertility Preservation in Patients Receiving Cytotoxic or Immunomodulatory Agents	Derived from Digest of Actions rather than Annual Digest of Actions: RESOLVED, That our AMA-RFS support: (1) payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or by necessary cytotoxic and/or immunomodulatory therapies as determined by a licensed physician; and (2) lobbying for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary cytotoxic and/or immunomodulatory therapies as determined by a licensed physician.	No action; already in Digest.
Resolution 8: Overemphasis on P-Values in Medical Literature	RESOLVED, that our AMA-RFS and AMA discourage the use of generalized qualitative statements of significance, such as through the use of p-values, without the reporting of effect-size, such as through the use of confidence intervals; and be it further RESOLVED, that our AMA-RFS and AMA encourage the formation of a clear distinction between statistical significance and clinical significance in the planning and reporting stages of scientific research; and be it further RESOLVED, that our AMA-RFS encourage, through formal communication to major medical journals and publications, efforts to improve scientific integrity in medical literature by: ● discouraging the reporting of hypothesis testing with generalized phrases such as "significant" or "p-value < 0.05";	No action; already in Digest.

	● promoting the reporting of effect size and measures of spread or variability, such as confidence intervals and standard deviations; ● requiring that authors clearly distinguish between accepted levels of statistical significance and clinical significance; and ● making efforts to anticipate and avoid language that may mislead as to the importance or impact of a statistical outcome when communicating the results of medical studies to the general public; and be it further RESOLVED, that our AMA-RFS support efforts to incorporate ongoing education on statistical interpretation and reporting in undergraduate, graduate, and continuing medical education with an emphasis on interpreting the distinction between clinical and statistical significance.	
Resolution 11: Development and Promotion of Use of Single National Prescription Drug Monitoring Program (PDMP)	RESOLVED, that our AMA encourage the creation of one national prescription drug monitoring program (PDMP) database of controlled substances for physicians to detect and monitor prescription drug abuse; and be it further RESOLVED, that our AMA oppose ~~*Ensuring Patient Access and Effective Drug Enforcement Act of 2014* (H.R. 4069) and any similar~~ requirements that ~~require~~ physicians must ~~to~~ consult such programs before prescribing medications; and be it further ~~RESOLVED, that our AMA support the creation of a national PDMP database which allows for an online log of patient controlled prescriptions filled and with proactive mechanisms that alert physicians to suspicious prescribing behavior under their name and patient receiving similar controlled substances from multiple prescribers; and be it further~~ RESOLVED, that this resolution be immediately forwarded to the HOD at A-14. ~~The AMA-RFS consider sending to AMA HOD at A-14 given the urgency of H.R. 4069.~~	No action; already in Digest.
Resolution 14: Improving Familiarity and Utilization of Mobile Medical Technology	RESOLVED, that our AMA-RFS support the development of educational programming ~~develop programming to educate residents and fellows~~ on how to use ~~these~~ mobile medical applications for clinical decision- making support, for communication with patients, and how to advise patients to best use mobile technology for health benefit; and be it further RESOLVED, that our AMA-RFS encourage our AMA to work with other interested stakeholders such as the innovators of existing mobile applications and other medical societies to develop or improve existing mobile applications to deliver accurate medical information based on current medical guidelines. ~~; and be it further~~ RESOLVED, that our AMA-RFS encourage our AMA to educate physicians on discerning between evidence-based mobile applications and mobile applications that are not medically accurate. ~~,and develop a list of "quality mobile~~	No action; already in Digest.

	~~applications" that are evidence based and user friendly for provider use and for providers to recommend to their patients; and be it further~~ ~~RESOLVED, that this resolution be forwarded to the AMA HOD for consideration at A-14.~~	
Resolution 15: Regulation of Electronic Nicotine Delivery Systems (ENDS)	RESOLVED, that our AMA-RFS support taxing, labelling and regulating electronic nicotine delivery systems (ENDS) as tobacco products and drug delivery devices; and be it further RESOLVED, that our AMA-RFS support legislation that restricts the minimum age, locations of permissible use, advertising, promotion, and sponsorship of ENDS to that of tobacco products; and be it further RESOLVED that our AMA-RFS support transparency and disclosure concerning the design, content and emissions of ENDS; and be it further RESOLVED, that our AMA-RFS recommend secure, child proof, tamper proof packaging and design of ENDS; and be it further RESOLVED, that our AMA-RFS support enhanced labelling that warns of the potential consequences of ENDS use~~,~~ ~~restriction of ENDS marketing as tobacco cessation tools,~~ restriction of ENDS marketing as tobacco cessation tools until clear evidence based research arises suggesting the contrary, as well as restriction of the use of characterizing flavors in ENDS; and be it further RESOLVED, that our AMA-RFS encourage basic, clinical, and epidemiological research concerning ENDS. ~~; and be it further~~ ~~RESOLVED, that our AMA-RFS forward this resolution to the AMA HOD at A-14.~~	No action; already in Digest.
Report E: Delegate Counts for Assembly Meetings	No text in Summary of Actions and no text in Digest.	Recommend reconciliation.
Interim 2014		
Resolution 1: Principles of Human Subjects Research Shall Apply to Online Research Projects	RESOLVED, That our AMA shall declare social media sites' Terms of Service as an insufficient proxy for informed consent prior to being enrolled in an experiment; and be it further RESOLVED, That our AMA recommend that ~~any member of an~~ online social networks ~~be given~~ provide users with specific informed consent outlining the aims, risks and possible benefits of an experimental ~~research~~ study prior to ~~their~~ study enrollment. ~~; and be it further~~ ~~RESOLVED, That this resolution be immediately forward to the AMA HOD at I-14.~~	No action; already in Digest.
Resolution 2: Allowing the AMA-RFS Delegation to Act as a	No text in Summary of Actions however generated report in subsequent meeting.	No action; generated a report.

Representative Body		
Resolution 5: AMA Response to Epidemics and Pandemics	RESOLVED, That our AMA provide regular updates in a timely manner on any disease classified by the World Health Organization as urgent epidemics or pandemics potentially affecting the US population; and be it further RESOLVED, That our AMA work with the CDC and international health organizations to provide organizational assistance to curb epidemics, including calling on American physicians to provide needed resources such as human capital and patient care related supplies; and be it further RESOLVED, That our AMA encourage relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics; and be it further RESOLVED, That this resolution be immediately forwarded to the HOD at I-14.	No action; already in Digest.
Resolution 6: Encouraging Protocols to Assist with the Management of Obese Patients	~~RESOLVED, That our AMA encourage providers to address the logistical requirements of caring for obese patients safely, efficiently and effectively and develop obesity protocols to address issues including but not limited to equipment, imaging machines, and transportation devices; and be it further~~ RESOLVED, That our AMA encourage ~~providers to train~~ healthcare providers ~~professionals and protect them from~~ to learn about techniques and devices to prevent potential injury and to provide safe and efficient care ~~in caring~~ for obese patients.	No action; already in Digest.
Resolution 7: Mitigation of Physician Performance Metrics on Trainee Autonomy and Education	RESOLVED, that our AMA ~~study the~~ assess ways to mitigate the negative effects of physician performance metrics on trainee autonomy and clinical experience during ~~reporting programs on the quality of~~ residency and fellowship training.~~; and be it further~~ ~~RESOLVED, that our AMA advocate that Sunshine Act disclosures related to clinical training for residents and fellows be exempt from reporting.~~	No action; already in Digest.
Resolution 9: Addressing Immigrant Health Disparities	RESOLVED, That our AMA urge federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children ~~populations~~ regardless of legal status, based on medical evidence and disease epidemiology; and be it further RESOLVED, That our AMA, ~~as a professional society , commit to standing against scaremongering, profiling and other stigmatizing and discriminatory practices, intentional or unintentional,~~ advocate against and publically correct medically inaccurate accusations that contribute to anxiety, fear, and marginalization of specific populations ~~based on inaccurate accusations that they pose a threat to public health working with state chapters, educating members, taking public positions and providing professional guidance against scaremongering~~; and be it further RESOLVED, That our AMA advocate for policies to make available and effectively deploy resources needed to narrow	No action; already in Digest.

	health disparities borne by immigrants, refugees or asylees.	
Resolution 10: Sustainable Community Based Falls Prevention Programs to Optimize Functional Outcomes in Elderly Populations	RESOLVED, That our AMA to work with ~~the~~ ~~CDC, Department of Public Health, and~~ relevant ~~agencies~~ organizations to ~~support~~ encourage research into community-based falls prevention programs. ~~to strengthen their overall efficacy and sustainability and~~ ~~to optimize functional outcomes for the~~ ~~elderly.~~	No action; already in Digest.
Resolution 12: Physician and Health Institution Publicity and Responsibility	RESOLVED, That our AMA encourage physicians when engaged in public discourse related to health and medical science to disclose whether stated positions are based on rigorously tested evidence, standard of care, or personal opinion.	Add to Digest.
Annual 2015		
Resolution 1: Filming Patients for News or Entertainment	RESOLVED, That our AMA-RFS ~~adopt policy which states~~ assert that ~~study whether when filming in the health care setting~~, efforts to disguise a patient (such as blurring the face, changing the voice, or any other technique) do not ~~may~~ obviate the need to obtain consent as outlined in AMA Policy E-5.045 for publication of any material related to the treatment of a patient.	No action; already in Digest.
Resolution 2: Smoke Free Residential Housing	RESOLVED, That our AMA-RFS shall encourage health care institutions that provide employee housing to make such housing smoke free to the extent allowed by applicable local laws.	No action; already in Digest.
Resolution 4: Improving Physician Well-Being by Exploring Partnerships with Companies that Promote Health and Fitness	RESOLVED, That our AMA-RFS ~~Board of Trustees ask AMA management to~~ evaluate entering into arrangements with companies which promote health and fitness that are willing to provide discounts to AMA-RFS members.	No action; already in Digest.
Resolution 5: Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance	RESOLVED, that our AMA study ways to improve access and reduce barriers to seeking ~~mechanisms, such as through existing accreditation and survey processes, to track whether residency programs are adequately providing for their trainees' ability to access necessary~~ preventive and routine physical and mental health care for trainees in graduate medical education programs.	No action; already in Digest.
Resolution 6: Evaluation of Resident and Fellow Compensation Levels	RESOLVED, That our AMA develop recommendations for appropriate ~~adjustments~~ protections and increases to resident and fellow compensation and benefits with input from residents, fellows, and other involved parties including residency and fellowship programs.~~; and be it further~~ ~~RESOLVED, That our AMA assess the impact on the compensation and benefits of residents and fellows from future or current implementation of the Institute of Medicine's report on the Governance and Financing of Graduate Medical Education.~~	No action; already in Digest.
Resolution 7:	RESOLVED, that our AMA-RFS oppose discrimination	No action; already

Discrimination Against Persons with HIV/AIDS Seeking Rehabilitative, Residential, and Nursing Care Placements	against persons with HIV/AIDS seeking rehabilitative, residential, and nursing care placements for the reason of HIV/AIDSpositive status.~~; and be it further RESOLVED, that our AMA oppose discrimination against persons with HIV/AIDS seeking rehabilitative, residential, and nursing care placements for the reason of HIV/AIDS-positive status; and be if further~~ ~~RESOLVED, that our AMA encourage practices and policies, consistent with existing federal, state, and local law and regulations, that protect and affirm the rights of persons with HIV/AIDS seeking rehabilitative, residential, and nursing care placements.~~	in Digest.
Resolution 8: Definition of Resident and Fellow	RESOLVED, that the AMA Council on Constitution and Bylaws develop amendments to the existing bylaws to accomplish the following: For purposes of membership in the AMA-RFS, the term Resident shall be applied to any physician who meets at least one of the following criteria: 1) Members who are enrolled in a residency approved by the ACGME or the AOA 2) Members who are active duty military or public health service residents required to provide service after their internship as general medical officers (including dive medical officers or flight surgeons) before their return to complete a residency program and are within the first five years of service after internship 3) Members serving, as their primary occupation, in a structured educational, vocational, or research program of at least one year to broaden competency in a specialized field prior to completion of their residency For purposes of membership in the AMA-RFS, the term Fellow shall be applied to any physician who has graduated from residency, and meets at least one of the following criteria: 1) Members serving in fellowships approved by the ACGME or AOA 2) Members serving, as their primary occupation, in a structured clinical, educational, vocational, or research training program of at least one year six months to broaden competency in a specialized field, ~~provided it is prior to their working as an independent attending physician;~~ and be it further; and For purposes of membership in the AMA-RFS, any physician meeting the definition of Resident or Fellow shall be eligible for discounted membership dues to the AMA and membership within the AMA Resident and Fellow Section.	Recommend reconciliation; likely to have generated "530.002R. Definition of a Resident" but does not actually establish RFS policy to reference.
Resolution 10: Childcare and Family Entertainment at AMA Meetings	RESOLVED, that our AMA-RFS study and report back, by I-15, on the feasibility of working with ~~our AMA Alliance and other~~ interested organizations to provide: ~~1) Structured activities for travelling family members of~~	No action; already in Digest.

	~~members of our House of Delegates, including:~~ ~~a) the number of spouses/significant others/family members who travel to the Annual and Interim meetings of the House of Delegates and its member sections and the number of spouses/significant others/family members who would travel to the House of Delegates meetings if structured activities were available~~ ~~2)~~ 1) Onsite, low cost, age-appropriate ~~activities and~~ childcare ~~for~~ during AMA meetings, ~~children of our House of Delegates and its member sections,~~ including but not limited to: ~~a)~~ the appropriate hours to providing such childcare, ~~b)~~ the cost associated with such childcare, ~~c)~~ the number of members of our House of Delegates and its member sections who bring their children to the meeting as well as the number of members of our House of Delegates and its member sections who would bring their children to the meeting were such childcare available	
Resolution 11: Increasing Awareness of Nootropic Use	Marked as Adopted as Amended however no text and marked as "NA" regarding HOD Action, but has similarly titled policy in HOD Compendium H-95.935.	Recommend reconciliation; likely add to digest.
Resolution 12: Physician and Health Institution Publicity and Responsibility	RESOLVED, That our AMA encourage physicians when engaged in public discourse related to health and medical science to disclose whether stated positions are based on rigorously tested evidence, standard of care, or personal opinion.	Recommend reconciliation; likely duplicative of Resolution 12 at I-14 .
Resolution 14: Banning the Artificial Use of Trans Fats in the United States	RESOLVED, that our AMA-RFS support a total ban on using artificial trans fats ~~partially hydrogenated oil~~ in food products.	No action; already in Digest.
Resolution 15: Balloting Procedures	RESOLVED, that our AMA-RFS study alternate procedures for balloting including but not limited to: (1) coordinating with the MSS, OMSS, and any other AMA entities to use pre-existing AMA balloting equipment before HOD sessions; (2) develop or have outside vendors develop a unique computer program to handle AMA-RFS elections; (3) use an existing Internet or nonInternet based ballot counting computer program; and implement such measures found to be most appropriate by Interim 2015.	No action; generated a report.
Resolution 16: Telemedicine in Graduate Medical Education	RESOLVED, that our AMA advocate for educating resident and fellow physicians during their training on the use of tele-health technology in their future practices, and be it further; RESOLVED, that our AMA study the barriers to optimizing the use of tele-health technology for the purposes of tele-education and specifically tele-precepting in Graduate Medical Education and the solutions to overcoming these barriers, and be it further; RESOLVED, that this resolution be forwarded to the House of	No action; already in Digest.

	Delegates at A-15.	
Resolution 17: Mental Health Services for Medical Staff	RESOLVED, that our AMA encourage health systems, hospitals, and medical schools to offer physicians and medical students access to confidential and comprehensive mental health services not affiliated with their place of employment.	Add to Digest.
Resolution 18:NonMedical Vaccination Exemptions	RESOLVED, That our AMA-RFS advocate for the removal of all state-based, non-medical exemptions to vaccination in accordance with each state's list of required vaccinations; and be it further RESOLVED, That our AMA-RFS support legislative efforts that would establish national vaccination requirements for minors.	No action; already in Digest.
Resolution 20: Principles of GME Funding Reform	~~RESOLVED, That our AMA supports the following principles for Graduate Medical Education Funding Reform:~~ ~~(1) Funding for Graduate Medical Education should be based on the actual costs to train and educate a resident/fellow including yearly adjustments for geographic and inflationbased cost-of-living;~~ RESOLVED, That our AMA supports that federal funding for Graduate Medical Education should be based on the actual costs to train and educate a resident/fellow (including but not limited to salary and benefits and institutional support for training and education) including yearly adjustments for geographic and inflation-based cost-of-living; and be it further RESOLVED, That our AMA supports~~(2)~~ that the allocation of Graduate Medical Education funds within an institution should be transparent and accountable to all stakeholders; and be it further RESOLVED, That our AMA support that ~~(3)~~ federal funding for Graduate Medical Education should strive to meet the health needs of the public including but not limited to size of the training program, geographic distribution, and specialty mix; and be it further ~~(4) Federal funding for Graduate Medical Education from the Centers for Medicare/Medicaid Services or a federal successor should be disbursed through a single transparent funding stream.~~ ~~RESOLVED, That our AMA Support that federal funding for graduate Medical Education should strive to meet the health needs of the public including but not limited to the size of the training program, geographic distribution, and specialty mix; and be it further~~	No action; already in Digest.

	RESOLVED, That our AMA support that federal funding for Graduate Medical Education from the Centers for Medicare/Medicaid Services or a any federal successors should be disbursed through a single transparent funding stream while maintaining opportunities for a multi-payor system; and be it further ~~that provides flexibility for innovation in training and education in addition to current levels of funding; and be it further~~ RESOLVED, That our AMA support additional federal funding for Graduate Medical Education that provides flexibility for innovation in training and education above and beyond current levels of funding; and be it further	
Resolution 21: Ethical Physician Conduct in the Media	RESOLVED, That our AMA report on the professional ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication; and be it further RESOLVED, That our AMA study disciplinary pathways for physicians who violate ethical responsibilities through their position on a media platform; and be it further RESOLVED, That our AMA release a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media~~.~~; and be it further RESOLVED, that this resolution be immediately forwarded to our AMA House of Delegates at A15.	No action; already in Digest.
Report A: Education in Business and Economics	The American Medical Association Resident and Fellow Section Governing Council recommends the following be adopted and the remainder of this report be filed: 1. That our AMA collaborate with appropriate organizations and committees to develop business and economics educational materials to be incorporated into graduate and undergraduate medical education. These materials could include, but are not limited to: 1) a model curriculum; 2) a competency evaluation mechanism; and 3) a strategy for elucidating the effect of such education on important outcomes including: physician readiness to practice, patient outcomes, and health care service utilization and physician satisfaction. 2. That our AMA offer education in business and economics to residents and fellows in the form of online modules, live seminars or other already planned AMA strategies for dissemination of educational materials. 3. That our AMA encourage medical schools and residency programs to make educational resources on personal finance and healthcare economics available to all of their trainees.	Add to Digest.

Report B: AMA-RFS Caucus Structure and Function	Recommendations 1. That our AMA-RFS amend its Internal Operating Procedures to reflect the following structure and rules of the Residents and Fellows Caucus of the AMA House of Delegates: A. RFS Caucus Structure 1. The RFS sectional and alternate delegates, together with the RFS Delegate and Alternate, form the RFS Caucus. 2. The RFS Delegate and RFS Alternate Delegate should be considered the chair and vice chair of the caucus respectively and their responsibilities in those positions include, but are not limited to: a. Overseeing debate, discussion, and voting that occurs within the caucus, or designating a member of the caucus to fulfill this role if they are unable to perform it themselves. b. Assigning sectional and alternate delegates to reference committees c. Speaking on behalf of the RFS in reference committee hearings and the HOD, or delegating the responsibility to speak on behalf of the RFS to other members of the section. d. Developing general RFS strategy for passing or defeating resolutions e. Coordinating and negotiating with the leadership of other groups within the HOD. 3. Other resident and fellow delegates to the AMA HOD, including residents or fellows appointed to their state or specialty delegations, are not considered members of the caucus. They are encouraged to take part in RFS Caucus meetings and participate in discussions. If willing, they may still be assigned to speak on behalf of the RFS by the RFS Delegate. B. Determining RFS Caucus Positions on AMA HOD Resolutions 1. For all RFS Caucus activities requiring a vote, all members of the caucus shall be given one vote. 2. A quorum of at least 50% of voting members must participate for a vote to be valid. 3. In the AMA HOD, the RFS Caucus must take positions on resolutions that are consistent with the existing policy of the RFS as defined in the RFS Digest of Actions whenever possible. 4. In areas where relevant RFS policy exists, but the interpretation is uncertain, a majority vote of a quorum of delegates will determine the caucus's interpretation.	No action; change in IOP.

	5. When a resolution is before the AMA HOD for which RFS policy does not exist, any member of the RFS Caucus may move that the RFS take a position on the resolution. Such a movement requires a second by another caucus member and a 2/3rds majority vote to pass. 6. Positions set using the procedures described in section B.5 are valid for the duration of that meeting only, and do not apply to future interim or annual meetings. C. Reporting of Caucus Actions 1. The RFS Delegate and Alternate shall be responsible for authoring a report of actions taken, which shall be presented to the RFS Assembly at the next national meeting. This report will list the resolved clauses of all AMA HOD resolutions for which the RFS took a position, and will specifically identify those resolutions for which the RFS Caucus took a position that was not grounded in existing internal policy. It will also detail the action taken, motivation for taking such action, and suggestions for new AMA-RFS policy on the issue in question.	
Report C: Resident and Fellow Physician Health and Wellness	Recommendations The American Medical Association Resident and Fellow Section Public Health Committee recommends the following be adopted and the remainder of this report be filed: 1. The AMA support educational initiatives to raise awareness about burnout, including but not limited to depression and suicide prevalence, among resident and fellow physicians. 2. The AMA collaborate with the ACGME, COCA, and other interested parties to promote training for residency and fellowship programs on recognizing, screening, and intervening in cases of resident and fellow physician burnout. 3. The AMA collaborate with the ACGME, COCA, and other interested parties to assist residency and fellowship programs in developing resident and fellow physician wellness initiatives. 4. The AMA promote a culture of resident physician wellness within physician training programs. 5. The AMA promote confidential and accessible mental health services for resident and fellow physicians. 6. The AMA encourage further research on the causal factors of resident and fellow physician burnout and its sequelae, including but not limited to its effect on quality of healthcare delivery and patient health outcomes.	Add to Digest.
Report D: Sunset Mechanism	Resolved clauses of report not listed in Summary of Actions.	Recommend reconciliation; likely generated bylaws report and may not require any action.
Interim 2015		

Late Resolution 1: Clarification of Medical Necessity for Treatment of Gender Dysphoria	RESOLVED, that our AMA recognize that treatment for gender dysphoria should be determined by shared decision making between patient and physician, consistent with generally-accepted standards of medical and surgical practice; and be it further RESOLVED, that our AMA ~~advocate for access to and reimbursement for medically necessary and appropriate treatment for individuals with gender dysphoria.~~ amend H-185.950 as follows: **H-185.950 Removing Financial Barriers to Care for Transgender Patients** Our AMA supports public and private health insurance coverage for treatment of gender ~~identity disorder~~ dysphoria as recommended by the patient's physician.	No action; already in Digest.
Late Resolution 2: NonMedical Indications for Hospitalization	RESOLVED, that our AMA oppose arbitrary time requirements of inpatient services in determination of eligibility for inpatient, outpatient or extended recovery, rehabilitative, or other post-hospital extended care services; and be it further RESOLVED, that our AMA oppose public and/or private insurance statutes, policies, and regulations that require hospitalization longer than medically necessary ~~for determination of benefit eligibility, including eligibility in order to be eligible~~ necessary for determination of benefit eligibility, including eligibility for skilled nursing facility care and other post-hospital extended care services; and be it further RESOLVED, that our AMA-RFS support changes in regulations that would include all continuous time spent in the hospital, including time spent in the emergency department, observational status or inpatient status, count toward any minimum length of stay requirement, should they exist	No action; already in Digest.
Late Resolution 3: Abuse of Free-Market Pharmaceuticals	RESOLVED, that our AMA-RFS advocate for pharmaceutical pricing that ~~the appropriate regulatory bodies of the federal government exercise its "march-in-rights" authority under the Bayh-Dole Act to assure the availability of pharmaceuticals at~~ is fair and reasonable ~~prices~~ to consumers, and be it further ~~RESOLVED, that our AMA-RFS reaffirms its policy of advocating that Medicare be granted the right to negotiate of drug prices with pharmaceutical companies.~~ RESOLVED, that our AMA-RFS advocate that the Centers for Medicare and Medicaid Services be granted the right to negotiate drug prices with pharmaceutical companies.	No action; already in Digest.
Resolution 2: Privacy Personal Use and Funding of Mobile Devices	RESOLVED, that our AMA-RFS support that physicians should not be required to use personal funding to purchase mobile devises (tablets, laptops, cell phones, PDAs, etc.) or their data plans for work-related purposes; and be it further	No action; generated a report.

	RESOLVED, that our AMA-RFS support that all physicians should retain their right to keep their personal information private and separate from the workplace, such as their home address and personal telephone number; and be it further RESOLVED, that our AMA-RFS support that if a person elects to use their own device, employers should provide full disclosure prior to use regarding their ability to monitor and access personal information; and be it further RESOLVED, that our American Medical Association work with the Accreditation Council of Graduate Medical Education and other interested parties to develop and support policies that protect physicians' privacy relating to the use of personal technology in the workplace while minimizing financial burden.	
Resolution 3: Opposing Funding Reductions on Health Centers Receiving Title X and/or Medicaid Funding	RESOLVED, that our AMA support ~~men's and~~ ~~women's~~ access to preventative and reproductive health services for all patients and oppose ~~non-evidence-based~~ legislation and restrictions that diminish funding and/or access to such services; and be it further RESOLVED, that our AMA oppose ~~non-evidence-based~~ restrictions for funding of all providers and clinics who provide preventive and reproductive health services, when those providers and clinics otherwise meet the usual standards for eligibility; and be it further RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at Interim 2015.	Add to Digest.
Resolution 5: Supporting Legislation to Create Student Loan Savings Accounts	RESOLVED, that our AMA advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.	No action; already in Digest.
Resolution 6: Conservation, Recycling, and Environmental Stewardship	RESOLVED, that our AMA encourages all health systems to facilitate effective and robust recycling programs with a recommended goal of a 25% rate when feasible; and be it further RESOLVED, that our AMA encourages all undergraduate and graduate medical education programs to facilitate effective and robust recycling programs when feasible; and be it further RESOLVED, that our AMA encourages health systems, medical schools, and graduate medical education offices to evaluate their overall environmental impact, create goals for improvement, and create a plan and a timeline to meet those goals; and be it further RESOLVED, that our AMA supports resources and incentives that aid and encourage hospital employees and physicians who partake in environmentally conscientious activities (benefits for carpooling or taking the bus, showers at work for	Add to Digest.

	biking/jogging to work, etc.).	
Resolution 7: Recognizing the Actual Costs of Student Loans	RESOLVED, that our AMA ~~recognize the total cost of student loans includes not only interest rates, but also loan origination fees as well as appreciate the value of some loans in terms of other benefits such as tax deductibility and loan forgiveness; and be it further~~ consider the total cost of loans including loan origination fees and benefits of federal loans such as tax deductibility or loan forgiveness when advocating for a reduction in student loan interest rates; and be it further RESOLVED, that our AMA amend D-305.984 to include Grad-PLUS loans ~~and reflect the actual total cost of loans such that we not only advocate for loan rates, but also other costs of loans~~, as follows: ~~; and be it further~~ **D-305.984 Reduction in Student Loan** **Interest Rates** 1. Our American Medical Association will actively lobby for legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 5.0%. 2. Our AMA will work in collaboration with other health profession organizations to advocate for a reduction of the fixed interest rate of the Stafford student loan program and the GradPLUS loan program. RESOLVED, that our AMA advocate for policies which lead to equal or less expensive loans (in terms of loan benefits, origination fees, and interest rates) for Grad-PLUS loans as this would change the status quo of highborrowers paying higher interest rates and fees in addition to having a higher overall loan burden; and be it further RESOLVED, that our AMA ask the AAMC to collect data and report student indebtedness that includes total loan costs at time of graduation.	R1, R3, R4: Add to digest; note that amendment appears to have been passed. R2: Add to digest as internal policy.
Resolution 8: Information for Resident Grievances ~~Hotline and Website~~	RESOLVED, that our AMA-RFS should include on ~~add to~~ its RFS website a link to general information and resources addressing resident grievances. ~~to assist and help direct residents with grievances to the appropriate venue. Said webpage would contain basic guidelines for filing a report, references to the resident bill of rights, and links to outside sources such as the NRMP, ACGME, etc. in order to guide a resident to resources to pursue to find a resolution for workforce issues and grievances; and be it further~~ ~~RESOLVED, that our AMA-RFS should request that the ACGME consider establishing an anonymous way for residents to submit grievances without fear or retaliation, either by a web submission form without identifying~~	No action; already in Digest.

	~~information via their website or a confidential grievance phone line as a resource.~~	
Resolution 9: ~~Physician Education in~~ In-Flight ~~Medicine~~ Medical Emergencies	~~RESOLVED, that our AMA-RFS encourage all resident training programs to promote familiarization of available inflight medical supplies, common IFMEs, and legal protections when responding to IFMEs.~~ ~~RESOLVED, that our AMA-RFS study physician familiarity with IFMEs and in-flight medical supplies.~~ RESOLVED, that our AMA work with the FAA and other appropriate organizations to require airlines provide a list of available inflight medical supplies in accessible locations. RESOLVED, that our AMA work with the FAA and other appropriate organizations to facilitate the creation of a centralized and standardized system to report all medical emergencies requiring assistance from a medically-trained passenger or from ground-based communications. RESOLVED, that our AMA work with the FAA and other appropriate organizations to ensure that a routine process exists to verify functionality of medical equipment and medicines used for in-flight medical emergencies.	Add to Digest.
Resolution 10: Evidence-Based Sexual Education Enforcement in School	~~RESOLVED, that our AMA advocate strongly for the promotion of evidence-based comprehensive sexuality education programs including but not limited to the following actions: 1) Encourage the Department of Health and Human Services to mandate evidence-based sexual education for all recipients of federally-derived sexual education programs funding; and 2) Encourage all States and US Territories to require primary and secondary school sexual education that is medically, factually and technically accurate.~~ RESOLVED, that our AMA encourage all interested parties to develop best-practice, evidence-based guidelines for developmentally appropriate sexual education curricula that are medically, factually, and technically accurate.	Add to Digest.
Resolution 11: Online Access to Prescription Drug Formularies	RESOLVED, that our AMA promote the value of online access to prescription drug formulary plans from all insurance providers nationwide; and be it further RESOLVED, that our AMA support state medical societies in advocating for state legislation of online access to prescription drug formularies for all insurance plans in the state health exchanges.	Add to Digest.
Report F: Childcare at the AMA Meetings	~~1. That our American Medical Association (AMA) not directly provide options for on site childcare at this time.~~ 1.~~2.~~ That our AMA ~~RFS ask the AMA~~ ~~and/or relevant subcommittee(s) to prepare a brief survey directed towards meeting attendees addressing the desire and need for future onsite childcare and report back on these results by A-17.~~ survey recent attendees of the AMA section meetings	No action; already in Digest.

	as well as the HOD on whether or not they have brought their children to AMA meetings and on the desire and need for onsite childcare and report back on these results at I-16. (Directive to Take Action) 2.~~3.~~ That ~~until such time as said survey is completed,~~ our AMA RFS Hospitality Committee and other relevant organizations ~~be~~ ~~asked to~~ publicize family friendly activity information within each meeting's respective host cities. (Directive to Take Action)	
	Annual 2016	
Late Resolution 2: Specialty-Specific Allocation of GME Funding	RESOLVED, that our AMA support specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty; and be it further RESOLVED, that this resolution be immediately forwarded to the HOD at A-16.	Add to Digest.
Resolution 1: Expansion of Public Service Loan Forgiveness	RESOLVED, that our AMA study mechanisms to allow residents and fellows working in for-profit institutions to be eligible for Public Service Loan Forgiveness, and be it further RESOLVED, that this resolution be forwarded immediately to A-16 HOD meeting.	No action; request for report.
Resolution 2: Inclusion of Sexual Orientation and Gender Identity (SOGI) Data Collection in Information in Electronic Health Records (EHRs)	RESOLVED, that our AMA advocate federal ~~agencies to include~~ for inclusion of sexual orientation and gender identity ~~(SOGI) data~~ collection in electronic health records (EHRs). ~~RESOLVED, that our AMA supports efforts to optimize sexual orientation and gender identity (SOGI) information data collection within standardized nomenclature systems.~~ ~~RESOLVED, that our AMA advocate for SOGI data collection in federal surveys and studies where appropriate.~~	Add to Digest.
Resolution 3: Universal Prescriber Access to Prescription Drug Monitoring Programs	RESOLVED, that our AMA support legislation and regulatory action that would authorize all prescribers of controlled substances, including residents, to have access to their state prescription drug monitoring program.	Add to Digest.
Resolution 4: Eliminating Legacy Admissions	RESOLVED, that our AMA-RFS oppose the use of legacy status in medical school applications forms. ~~RESOLVED, that our AMA oppose the use of legacy status in the residency application process.~~	No action; already in Digest.
Resolution 6: Expanding GME Concurrently with UME	RESOLVED, that our AMA study the effect of medical school expansion that occurs without corresponding graduate medical education expansion, and be it further RESOLVED, that this resolution be immediately forwarded.	No action; request for report.

Resolution 7: Chronic Trauma Encephalopathy (CTE)	RESOLVED, that our AMA amend H-470.954 to include a part (C)that appropriate agencies "promote education for physicians and the public on the detection, treatment and prognosis of chronic traumatic encephalopathy (CTE)." RESOLVED, that the AMA work with interested agencies and organizations to advocate for further research into the causes of and treatments for chronic traumatic encephalopathy (CTE).	Add to Digest.
Resolution 9: Firearm Background Checks	RESOLVED, that our AMA ~~amend H-145.996 as follows:~~ ~~**H-145.996 Handgun Availability**~~ ~~The~~ AMA-RFS (1) advocates a waiting period and background check for all ~~handgun~~ firearm purchasers; (2) encourages state and federal legislation that enforces a waiting period for all transactions, and background check for all purchasers, ~~and a license for all sellers~~ during firearm transactions ~~handgun purchasers~~; and (3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.	No action; already in Digest.
Resolution 10: Reducing Perioperative ~~Narcotic~~ Opioid Consumption	RESOLVED, that our AMA encourage hospitals to adopt practices for the management of perioperative pain that include services dedicated to acute pain management and the use of multimodal analgesia strategies aimed at ~~decreasing appropriate narcotic~~ minimizing opioid administration without compromising adequate pain control during the perioperative period. ~~RESOLVED, that our AMA encourage relevant stakeholders to introduce perioperative pain management billing codes and insurance reimbursement strategies.~~	Add to Digest.
Resolution 11: Expanding the Treatment of Opiate Dependence Using Medication-Assisted Treatment By Physicians in Residency Training Programs	RESOLVED, that our AMA encourage the expansion of residency and fellowship training opportunities to provide clinical experience in the medication-assisted treatment of opioid use disorders, under the supervision of an ~~addiction medicine~~ appropriately trained physician. RESOLVED, that our AMA support additional funding to overcome the financial barriers, ~~such as buprenorphine training and waivers, supervision by experienced addiction medicine physicians, and clinical infrastructure~~ that exist for trainees seeking clinical experience in the medication-assisted treatment of opioid use disorders.	Add to Digest.
Resolution 12: Protecting Rights of Breastfeeding Residents and Fellows	RESOLVED, that our AMA work with appropriate bodies, such as the ACGME, to mandate language in housestaff manuals or similar policy references of all training programs on the protected time and locations for milk expression and storage of breast milk; and be it further	Add to Digest.

	RESOLVED, that our AMA work with appropriate bodies, such as the ACGME and AAMC, to include language related to the learning and work environments for breast feeding mothers in regular program reviews.	
Resolution 13: Primary Care and Mental Health Training in Residency	~~RESOLVED, that our AMA advocate for enhanced funding for residency training programs which emphasize the integration of mental health and primary care.~~ RESOLVED, that our AMA advocate for the ~~inclusion~~ incorporation of integrated mental health and primary care services into existing psychiatry and primary care training programs' clinical settings. RESOLVED, that our AMA encourage primary care and psychiatry residency training programs to create and expand opportunities for residents to obtain clinical experience working in an integrated mental health and primary care model, such as the collaborative care model. RESOLVED, that our AMA advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.	Add to Digest.
Resolution 14: Universal Color Scheme for Respiratory Inhalers	RESOLVED, that our AMA work with leading respiratory inhaler manufacturing companies and health agencies such as the Federal Drug Administration (FDA) and the American Pharmacists Association (APhA) to develop consensus of a universal color scheme for short-acting beta-2 agonist respiratory inhalers that are used as "rescue inhalers" in the United States. RESOLVED, that our AMA work with leading respiratory inhaler manufacturing companies to ensure the universal color scheme for respiratory inhalers would allow for the least disruption possible to current inhaler colors, taking into account distribution of each brand and impact on current users if color were to change. RESOLVED, that our AMA work with leading respiratory inhaler manufacturing companies to ensure that universal color scheme for respiratory inhalers be designed for adherence and sustainability, including governance for future companies entering the respiratory inhaler market, and reserving colors for possible new drug classes in the future.	No action; already in Digest.
Resolution 15: Mitigating Abusive Pre-Certification/Pre-	RESOLVED, that our AMA-RFS oppose abusive practices by health insurance entities in pre-certification and pre-authorization of services and medications.	R1: No action; already in Digest. R2: Add to Digest.

Authorization Practices	RESOLVED, that our AMA encourage residency programs to offer administrative resources to housestaff for practice-based support including but not limited to pre-certification and pre-authorization of medications and services. RESOLVED, that this resolution be immediately forwarded to AMA-HOD at A-16.	
Resolution 16: Improving Access to Care Health Outcomes	~~RESOLVED, that our AMA encourages states to incorporate community health workers (CHW) in health care systems.~~ RESOLVED, that our AMA support training opportunities for students and residents to learn cultural competency from community health workers ~~(CHW)~~. ~~RESOLVED, that our AMA support legislation for reimbursement of community health workers (CHW).~~	Add to Digest.
Resolution 17: Accident Prevention: Concussions	RESOLVED, that our AMA-RFS ~~encourages states~~ support state-based initiatives to require prevention for all contact sports in pediatric and young adult populations by (1) ~~mandating~~ encouraging the use of protective equipment in sports, (2) ~~requiring~~ encouraging sports physicals to include a basic neurocognitive screening ~~evaluation~~ by qualified healthcare professionals ~~physicians~~ for pediatric and young adults populations ~~ages 8 to 21~~ playing contact sports (3) urging policy on return to play protocol for athletes to achieve optimal recovery and reduce or avoid long term health outcomes (4) advocating for education on increasing concussion awareness among the public, coaches and the medical community.	No action; already in Digest.
Report F: Privacy Personal Use and Funding of Mobile Devices	Recommends that the AMA-RFS Governing Council recommends the following be adopted and the remainder of this report be filed: 1. That our AMA encourage further research in integrating mobile devices in clinical care, particularly to address challenges of reducing work burden while maintain clinical autonomy for residents and fellows; 2. That our AMA collaborate with the ACGME to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure a more uniformed regulation of mobile devices in medical education and clinical training. 3. That our AMA encourage medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines in using personal devices in clinical environment.	No action; already in Digest.
Report G: ~~Marijuana and the Cannabinoid~~	Medicinal Cannabis: 1. That the RFS support state and federal based legalization of ~~marijuana/cannabinoids~~ cannabis for ~~both~~ medicinal ~~and~~	No action; internal policy was adopted and amendments

~~Conundrum~~: Clinical Implications and Policy Considerations of Cannabis Use	~~recreational~~ use ~~so they may be regulated and taxed similar to tobacco products.~~ 2. That the RFS support regulation of medicinal cannabis in states that have legalized its use. 3. That the RFS support funding and other efforts to continue research into the efficacy and side effects ~~public health consequences~~ of both medicinal ~~and recreational marijuana/cannabinoid~~ cannabis use. Recreational Cannabis: 4. The RFS supports the decriminalization of recreational cannabis. 5. That the RFS supports taxation and regulation of recreational cannabis in states that have legalized the sale and use of recreational cannabis. ~~encourage states who have legalized and currently tax marijuana/cannabinoids to allocate a portion of tax revenue towards marijuana/cannabinoid education and harm reduction public health strategies.~~ 6. That the RFS supports funding, including the allocation of a portion of cannabis sales tax revenue, toward cannabis abuse education programs, harm reduction strategies, and continued research into public health consequences of recreational cannabis use. Medicinal and Recreational Cannabis Use: 7. That the RFS support public health based strategies, rather than incarceration, in handling of individuals possessing cannabis for personal use in states where it is not currently legal. ~~That the RFS support restrictions on marijuana/cannabinoids the sale of recreational cannabis sale for both medicinal and recreational use to non-minors. and those otherwise deemed old enough to consume alcohol.~~ ~~That Policy H-170.992 "Alcohol and Drug Abuse Education", Policy H-95.936 "Cannabis Warnings for Pregnant and Breastfeeding Women", and Policy H-95.938 "Immunity From Federal Prosecution for Physicians Recommending Cannabis" be reaffirmed by the RFS.~~ Policy Amendments: 8. That our ~~the RFS ask the~~ AMA ~~to~~ amend policy **H-95.998** by addition and deletion to read as follows: Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; ~~(2) sale of cannabis should~~ ~~not be legalized; (3)~~ (2) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use; and ~~(4)~~ (3) additional research should be encouraged. 9. That our ~~the RFS ask the~~ AMA ~~to~~ amend policy **D-95.976** by deletion to read as follows:	would not affect internal policy.

	Our AMA will educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH Report 2, I-13, A Contemporary View of National Drug Control Policy, and CSAPH Report 3, I-09, Use of Cannabis for Medicinal Purposes, and as additional scientific evidence becomes available. 2. Our AMA urges legislatures to delay initiating full legalization of any cannabis product until further research. is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research. 3. Our AMA will also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a "public health", as contrasted with a "criminal," approach to cannabis. 4. Our AMA shall encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: ~~"Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States."~~	
	Interim 2016	
Late Resolution 3: The DEA Order to Reduce Opioid Production	RESOLVED, That our AMA encourage relevant stakeholders to research the overall effects of opioid production cuts; and RESOLVED, That our AMA encourage the DEA to postpone any opioid production cuts until the potential effects of production quotas are better elucidated; and, RESOLVED, That our AMA encourage the DEA to be more transparent when developing medication production guidelines; and	Add to Digest.
Resolution 1: Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking	RESOLVED, That our AMA advocate for tobacco harm reduction approaches to be added to existing tobacco treatment and control efforts; and be it further RESOLVED, That our AMA educate physicians and patients on the myriad health effects of different nicotine products and emphasize the critical role of smoke and combustion in causing disease; and be it further RESOLVED, That our AMA encourage physicians to adopt patient-specific, individualized approaches to smoking cessation, particularly for patients with disease secondary to smoking and for patients who have otherwise failed traditional methods for smoking cessation; and be it further RESOLVED, That our AMA continue its focus on research to	Add to Digest.

	identify and expand options that may assist patient to transition away from smoking, including nicotine replacement therapies and noncombustible nicotine products (including e-cigarettes); and be it further RESOLVED, That the AMA reaffirm its position on strong enforcement of FDA and other agency regulations for the prevention of use of all electronic nicotine delivery systems (ENDS) and tobacco products by anyone under the legal minimum purchase age. This shall include marketing to children, direct use or purchasing by children and indirect diversion to children. Further, the AMA shall reaffirm physician education of patients to limit these products for children in any and all capacity.	
Resolution 2: Legislative Pain Care Restrictions	RESOLVE, that our AMA-RFS oppose legislative or other policies that harm patients by restricting their ~~arbitrarily restrict a patient's~~ ability to receive effective, patient-specific, evidence-based, comprehensive pain care.	No action; already in Digest.
Resolution 3: Eliminating Financial Barriers for Evidence-Based HIV Pre-Exposure Prophylaxis	RESOLVE, That our AMA amend policy H-20.895 by addition to read as follows: **Pre-Exposure Prophylaxis for HIV H-20.895** 1. Our AMA will educate physicians and the public about the effective use of pre- exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances (Res. 106, A-16) 3. Our AMA advocate that individuals not be denied various financial products, including disability insurance, on the basis of HIV pre-exposure prophylaxis (PrEP) use.	Add to Digest.
Resolution 4: Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons	RESOLVED, That our AMA will support the implementation of routine screening for HCV in prisons; and be it further RESOLVED, That our AMA will advocate for the initiation of treatment for HCV in all incarcerated patients with the disease and seeking treatment; and be it further RESOLVED, That our AMA will support negotiation for affordable pricing for therapies to treat and cure Hepatitis C virus ~~Direct Acting Antiviral Medication therapies~~ between among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.	Add to Digest.
Resolution 6: Funding for Emergent Communicable Disease Public Health Crises ~~Zika Control and Research~~	~~RESOLVED, That our RFS support AMA efforts in urging Congress to enact legislation that provides increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus commensurate with the public health emergency that the virus poses without diverting resources from other essential health initiatives.~~	No action; already in Digest.

	RESOLVED, That our RFS support AMA efforts in urging Congress to expeditiously act to ensure sufficient funding for research, prevention, control, and treatment of newly identified communicable diseases that pose a public health emergency without diverting resources from other essential health initiatives.	
Resolution 7: Fair Access to Evidence-Based Family Planning Methods	~~RESOLVE, That our AMA-RFS support all family planning methods including medical or surgical termination of pregnancy which are supported by evidence of improvements in health outcomes in patients of reproductive age.~~ RESOLVE, That our AMA-RFS recognize that choices regarding family planning and medical or surgical termination of pregnancy are personal and autonomous and are to be made by a patient in concert with their health care provider ~~as they see fit.~~ RESOLVE, That our AMA-RFS support changes to public and private payment mechanisms that would make evidence-based family planning methods and medical or surgical termination of pregnancy accessible to all patients, regardless of socioeconomic background. ~~RESOLVE, That our AMA-RFS support sufficient compensation by public and private payors for the acquisition of family planning supplies and the delivery of services by clinicians.~~ ~~RESOLVE, That our AMA-RFS recognize that family planning is a personal and autonomous decision to be made by a patient with consultation of the clinician and partner, as desired.~~	No action; already in Digest.
Resolution 8: Mental Health Disclosures on Physician Licensing Applications	RESOLVED, That our AMA encourage state medical boards to consider physical and mental conditions similarly. RESOLVED, That our AMA encourage state medical boards to recognize that the presence of a mental health condition does not equate with an impaired ability to practice medicine. RESOLVE, that our AMA amend policy Licensure Confidentiality H-275.970 by addition and deletion to read as follows: **Licensure Confidentiality H-275.970** The AMA (1) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards, to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (2) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (3) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (4) encourages state medical societies and specialty societies to	R1, R2, R4: Add to Digest. R3: Add to Digest as internal policy.

	join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (5) encourages state licensing boards to require disclosure of physical or mental health history by physician health programs or providers only if they believe the illness of the physician they are treating is likely to impair the physician's practice of medicine or presents a public health danger. ~~that, if an applicant has had psychiatric treatment, the physician who has provided the treatment submit to the board an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.~~ (CME Rep. B, A-88 Reaffirmed: BOT Rep. 1, I-933 CME Rep. 10 - I 94 Reaffirmed: CME Rep. 2, A-04 Reaffirmed: CME Rep. 2, A-14) RESOLVED, That our AMA encourage state medical societies to advocate that state medical boards not ~~change policies which reserve the right to issue~~ sanction~~s to~~ physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.	
Resolution 9: Interpretation of Governing Council Responsibilities Regarding Actions of the RFS Sectional Delegate Caucus	~~RESOLVED, That our RFS Governing Council present actual language adopted by ad hoc actions of the AMA-RFS Caucus in a Consent Calendar format, subject to extraction and amendment by individual item.~~ ~~RESOLVED, That our AMA-RFS Caucus, acting as a Standing Committee of the RFS, introduce a single report for each meeting of the AMA House of Delegates that discusses, separately, each ad hoc action of the RFS Caucus which includes formal and actionable policy recommendations subject to debate and vote.~~ RESOLVED, That our AMA-RFS Governing Council Report on *ad hoc* actions of the AMA-RFS Caucus identify the names and endorsing groups of all attending members of the Caucus	No action; generated a report.
Resolution 10: Improving Drug Affordability	RESOLVED, That our AMA supports drug price transparency legislation that requires pharmaceutical manufacturers to disclose, in a timely fashion, the basis for the prices of all of prescription drugs, including but not limited to (1) research and development costs paid by both the manufacturer and any other entity; (2) manufacturing costs; (3) advertising and marketing costs; (4) total revenues and direct and indirect sales; (5) unit price; (6) financial assistance provided for each drug including any discounts, rebates and/or prescription drug assistance; (7) any offshoring of either jobs or profits; (8) any reverse payment settlements; (9) payments to third parties—such as wholesalers, group purchasing organizations (GPOs), managed care organizations (MCOs), and pharmacy benefit management companies (PBMs); and be it further RESOLVED, That our AMA support legislation that requires pharmaceutical manufacturers to provide public notice before increasing the wholesale price of any brand or specialty drug by 10% or more each year or per course of treatment; and be it further RESOLVED, That our AMA support legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical	Add to Digest.

	manufacturers and increase access to affordable drugs for patients. RESOLVED, That our AMA support the expedited review of generic drug applications and prioritize review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.	
Resolution 11: Reimbursement Neutrality in the Merit Based Incentive Payment System (MIPS) of MACRA	RESOLVED, That our AMA-RFS limit support of initiatives included in the Merit-Based Incentive Payment System (MIPS) to those which are projected to be neutral with respect to geography and specialty; and be it further RESOLVED, That our AMA-RFS advocate for transparency among public and private payors in the creation and utilization of formulas intended to rank physicians for the purposes of reimbursement of public comparison.	No action; already in Digest.
Report E: Resident Engagement In and Awareness of Value-Based Care and Reimbursement Strategies	The American Medical Association Resident and Fellow Section Committee on Quality Improvement and Patient Safety recommends the following be adopted and the remainder of this report be filed: 1. That our AMA-RFS support efforts to gather data on resident awareness of reimbursement models and the transition to quality-based and value-based reimbursement models. 2. That our AMA-RFS develop education materials for current residents and medical students that familiarize them with the concepts and theory of value-based reimbursement and the current and proposed value-based reimbursement strategies offered by major insurers. 3. That our AMA-RFS develop education materials designed to help physicians understand the role of quality metrics in designing a practice or in their contractual service to an employer 4. That our AMA work with governing bodies in medical education to encourage integration of value-based care training into graduate medical education programs 5. That our AMA advocate that the positive and negative impacts of value-based care and reimbursement on resident education to be studied, longitudinally followed, and reported nationally.	R1-R3: Recommend reconciliation; it is unclear why the originally supported internal policy was not added and if had been subsequently removed for some specific reason. R4, R5: Add to Digest.
	Annual 2017	
Late Resolution 1: Protection of Access and Coverage of Women's Preventative and Maternity Care	RESOLVE, that our AMA-RFS support ~~the continued efforts and~~ legislation and regulations that ensure~~s~~ women have comprehensive coverage and access to preventative care, contraception ~~contraceptives~~, and maternity care with no cost sharing.	No action; already in Digest.
Late Resolution 2: Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine	RESOLVED, That our RFS support conducting studies on the participation of academic and teaching physicians, residents, fellows, and medical students, and community-based faculty members of medical schools and graduate medical education programs in organized medicine on medical school campuses and in teaching hospitals; and be it further	No action; already in Digest.

	RESOLVED, That our RFS support identifying successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine at the training sites.	
Resolution 1: Improving FDA Expedited Approval Pathways	RESOLVED, That our AMA work with FDA and other interested stakeholders to design and implement via legislative action (including ensuring appropriate FDA staffing) a process by which drugs which obtain FDA approval via the Fast Track, Accelerated Approval, or Breakthrough Therapy pathways be granted FDA approval on a temporary basis not to exceed 5 years, ~~until permanent approval can be granted by the FDA based on a formal review of post-marketing surveillance data, and be it further pending further evidence of safety and efficacy that is at the level set for the standard drug approval process.~~ pending further evidence of safety and efficacy that is at the level set for the standard drug approval process. RESOLVED, That our AMA work with the FDA and other interested stakeholders to define "specialty drugs" and the process for designating "specialty drugs" for expedited approval pathways. ~~in improving the process by which drugs are selected for the expedited pathway to improve the prevalence of these drugs that are classified as "specialty drugs."~~	Add to Digest.
Resolution 2: Amendment to RFS Policy 410.030R	RESOLVED, That our AMA-RFS amend RFS policy 410.030R by addition to read as follows: **410.030R Emergent Communicable Disease Public Health Crises:** That our RFS support AMA efforts in urging Congress to expeditiously act to ensure sufficient funding for research, prevention, diagnosis, control, and treatment of newly identified communicable diseases that pose a public health emergency without diverting resources from other essential health initiatives. (Resolution 6, I-16)	No action; already in Digest.
Resolution 3: Harmful Effects of Screen time ~~and Blue Light Exposure with~~ Children	RESOLVED, That our AMA encourage ~~all~~ primary and secondary schools to incorporate into health class curriculum the topic of balancing screen time with physical activity and sleep; and be it further ~~RESOLVED, That the AMA encourage research into the utility of blue light filtering glasses and a blue light filter option on devices such as smart phones and tablets; and be it further~~ RESOLVED, That our AMA encourage primary care physicians to assess all pediatric patients and educate all parents about amount of screen time, physical activity and sleep habits.	Add to Digest.
Resolution 4: Education on, Screen, and Reporting of Elder Abuse and Neglect	RESOLVED, That our AMA-RFS promote elder abuse screening during patient encounters when deemed appropriate by the provider. ~~RESOLVED, That our AMA promote research to ascertain if the use of educational programs and interventions improves~~	No action; already in Digest.

	~~attitude and knowledge of all caregivers and ultimately leads to the reduction of elder abuse incidents.~~	
Resolution 5: RFS Sunset Mechanism	RESOLVED, That our AMA-RFS Governing Council present actionable sunset recommendations to RFS policy via a yearly report at our Annual Meeting; and be it further RESOLVED, That each adopted resolve or recommendation clause within an RFS policy shall be considered individually with regard to the sunsetting process; and be it further RESOLVED, That our AMA-RFS annually review ten-year-old RFS policies and recommend whether to (a) reaffirm the policy, (b) rescind the policy, (c) reconcile the policy with more recent and like policy, or (d) make editorial changes which maintain the original intent of the policy; and be it further RESOLVED, That each RFS sunset recommendation regarding RFS policy may be extracted from the Consent Calendar and handled individually by our Assembly, but may only be adopted or not adopted; and be it further RESOLVED, That an action of the RFS Assembly that retains or updates an existing RFS policy shall reset the sunset "clock," making the reaffirmed RFS policy viable for ten additional years; and be it further RESOLVED, That defeated RFS sunset recommendations be reaffirmed for one year, to be readdressed via RFS Governing Council report or resolution from the RFS Assembly at or prior to the next RFS Annual Meeting; and be it further RESOLVED, That nothing in this policy shall prohibit a report or resolution to sunset an RFS policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current RFS policy, or has been accomplished; and be it further RESOLVED, That **580.013R Sunset of AMA-RFS Policy** be rescinded.	No action; speaks to IOP.
Resolution 6: RFS Caucus Vote Mechanism	RESOLVED, That ~~prior to I-17,~~ following the conclusion of each House of Delegates meeting, not to exceed 30 days, our ~~Governing Council~~ RFS Delegate and Alternate Delegate will ~~develop a mechanism to~~ provide a brief summary of any ~~educate the RFS Assembly at large on the~~ *ad hoc* policy actions of the RFS Caucus as to allow related resolutions to be written within existing deadlines.	No action; speaks to IOP.
Resolution 8: Financial Protections for Doctors in Training	RESOLVED, That our AMA ~~support~~ study the impact of encouraging training programs to offer ~~retirement plans for all residents and fellows, which includes~~ retirement plan matching and the unique nature of vesting as applied to residents in order to further secure the financial stability of physicians in training ~~and increase financial literacy during training~~; and be it further	Add to Digest.

	RESOLVED, That our AMA ~~support~~ encourage ~~that all~~ training programs to provide financial education ~~advising~~ to residents and fellows.	
Resolution 10: Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training	That our AMA will: (1) Actively support the development and implementation of training in implicit bias, diversity and inclusion as a component of medical education ~~in all medical schools and residency programs~~; (2) Identify and publicize effective strategies for educating residents in all specialties about disparities in their fields according to race and ethnicity, with particular regard to access to care and health outcomes; and (3) Support research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes ~~according to race and ethnicity~~.	Add to Digest.
Report E: RFS Election Reform	1. AMA-RFS IOP VII.D.2-5 shall be amended by insertion and deletion to read: 2) Method of Endorsement. ~~Where there is o~~ Only one resident or fellow member of the AMA ~~candidate, endorsement~~ may be endorsed by the Resident and Fellow Section (RFS) Assembly to serve as the Resident and Fellow Trustee. ~~by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall be in order. Endorsements shall be by ballot. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no ranking, and it should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed.~~ 3) The AMA-RFS Assembly may endorse a resident or fellow member at the Interim Meeting to be a candidate for a *single election* ~~*term*~~. The Assembly may choose not to endorse any candidate for the position of Trustee. 4) ~~3. Processing.~~ Endorsements shall be by private ballot. No ballots will be cast after the expiration of the voting period. On the official ballot, votes may be cast for one candidate or for no candidates. ~~The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the boxes will be sequestered in a private location. At this time the Chair of the Rules Committee will open the ballot box and the Rules Committee will then count the ballots and tabulate the results. Counting shall proceed by counting the number of affirmative votes for each candidate. Every candidate who receives an affirmative vote from greater than 50% of those who cast legal ballots shall be endorsed.~~	No action; speaks to IOP.

	5) The candidate must receive an affirmative vote from greater than 50% of those who cast legal ballots from the AMA-RFS Assembly to be endorsed by the AMA-RFS. 6) As per RFS Internal Operating Procedures V.F.5.b, there shall be a run-off ballot between the two highest vote recipients in the event that no single candidate receives a majority of legal votes cast for a given office. 7) ~~4. Validating. Upon completion of the tabulation, the Chair of the Rules Committee will validate the election results by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed and will then certify the results in writing. He or she will then immediately forward these results to the Assembly's presiding officer.~~ The candidate who receives a majority of legal votes cast shall receive complete AMA-RFS endorsement. Upon receipt of the RFS Rules Committee's election results and verification, the presiding officer will announce the results to the Assembly. 8) ~~5. Late Endorsement.~~ At the time of the RFS Annual Meeting, if no candidate has been endorsed, ~~A~~a candidate may ask for endorsement by the Assembly at the ~~a~~Annual ~~m~~Meeting ~~of the Assembly~~. This is subject to the same rules described above and additionally requires a 2/3 vote of the Assembly for endorsement. ~~In the case of an individual seeking late endorsement, any individual who has already been endorsed for the position shall be allotted equal time before the Assembly and shall have his or her materials reprinted in the Assembly handbook upon request~~. 2. AMA-RFS IOP VIII.D.2-4 shall be amended by insertion and deletion to read: 2) Method of Endorsement: ~~Where there is only one candidate for a given council, endorsement may be by affirmation. When there are multiple candidates, a motion to endorse more than one candidate shall be in order. Endorsements shall be by ballot. There shall be a separate ballot for each Council. Votes shall be cast by approval balloting, such that any candidate whom the delegate deems worthy of endorsement should be marked affirmatively by that delegate. There shall be no ranking, and it should be made clear that marking a second candidate in no way jeopardizes the chances of a first candidate to be endorsed.~~ Only one resident or fellow member of AMA may be endorsed by the Resident and Fellow Section (RFS) Assembly to serve as a non-appointed Council member. 3) The AMA-RFS Assembly may endorse a resident or fellow member at the Interim Meeting to be a candidate for a *single election ~~term~~*. The Assembly may choose not	

	to endorse any candidate for the position of non-appointed Council member. 4) ~~3. Processing.~~ Endorsements shall be by private ballot. No ballots will be cast after the expiration of the voting period. On the official ballot, votes may be cast for one candidate or for no candidates. ~~The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the boxes will be sequestered in a private location. At this time the Chair of the Rules Committee will open the ballot box and the Rules Committee will then count the ballots and tabulate the results. Counting shall proceed by counting the number of affirmative votes for each candidate.~~ 5) ~~Every~~ The candidate ~~who~~ must receive~~s~~ an affirmative vote from greater than 50% of those who cast legal ballots from the AMA-RFS Assembly to ~~shall~~ be endorsed by the AMA-RFS. 6) As per RFS Internal Operating Procedures V.F.5.b, there shall be a run-off ballot between the 2 highest vote recipients in the event that no one candidate receives a majority of legal votes cast for a given office. 7) The candidate who receives a majority of legal votes cast shall receive complete AMA-RFS endorsement. Upon receipt of the Rules Committee's election results and verification, the prescribing officer will announce the results to the Assembly. 8) ~~4. Late Endorsement.~~ At the time of the RFS Annual Meeting, if no candidate has been endorsed, a ~~A~~ candidate may ask for endorsement by the AMA-RFS Assembly at the ~~a~~ Annual ~~m~~ Meeting ~~of the Assembly.~~ This is subject to the same rules described above and additionally requires a 2/3 vote of the Assembly for endorsement. ~~In the case of an individual seeking late endorsement, any individual who has already been endorsed for the position shall be allotted equal time before the Assembly and shall have his or her materials reprinted in the Assembly handbook upon request.~~ 1. AMA-RFS IOP VII AND VIII shall be amended by insertion to read: G. Expiration of Endorsement. Any endorsement of a resident or fellow member, whether endorsed by a specialty society, state society or the RFS Assembly, shall only be valid for two consecutive AMA-RFS Assembly and AMA House of Delegates meetings, which includes the meeting during which the initial endorsement was obtained. If a resident or fellow member is seeking re-endorsement following expiration of previous endorsement, the member would be required to obtain new endorsement for the desired position.	

	1. AMA-RFS IOP V.C.1 shall be amended by insertion to read: ~~1)~~All members of the RFS, including fourth year medical students who have matched into a residency program, are eligible for election to the Governing Council, provided that they do not hold other AMA-RFS ~~Leadership Positions~~ Governing Council Positions, Board of Trustees and RFS seats on HOD Councils with terms that would overlap with the desired Governing Council position, with the exception of RFS Chair-Elect. ~~These AMA-RFS Leadership positions include: RFS Governing Council positions and RFS positions on HOD Councils.~~	
Report F: Residency Transfers	1) That the AMA-RFS continue to actively promote the resident and fellow vacancy page. 2) That the AMA-RFS ~~consider organizing~~ organize the information, including links to specialty society websites, on the resident and fellow vacancy page in a user-friendly format. 3) That the AMA-RFS initiate conversation to integrate the resident and fellow vacancies into FRIEDA, a resource well known to residents and fellows, to make the information more widely distributed and easily accessible. 4) That the AMA-RFS include information about procedures and logistics of transferring residency and fellowship programs or specialties.	No action; already in Digest.
Report G: Fellowship Start Date	That the AMA survey physicians who have undergone ~~this~~ revised fellowship start dates to further evaluate the benefits and drawbacks from this transition.	No action; generated a report.
Report H: Health Fitness Partnership	We strongly urge the AMA: 1)To promote health and wellness among its members. 2)To further investigate and explore partnerships to promote health and wellness among its members, including a partnership that provides some financial benefit to AMA members.	Add to Digest.
	Interim 2017	
Emergency Resolution 1: Support of Protesting Resident Physicians in Poland	RESOLVED, That the AMA-RFS support the application of its ideals regarding the health of patients and the rights of physicians in training to all situations where inadequate health care systems and/or injustice exist regardless of national affiliation.~~; and be it further~~ ~~RESOLVED, That our AMA-RFS ask the AMA to issue a statement on the issue of the Polish junior physician protests encouraging a good faith dialogue between junior physicians and members of the Polish government to achieve the mutually beneficial goals of adequate healthcare spending, a sufficient healthcare workforce and improved working conditions and pay for physicians in training; and be it further (Directive to Action)~~ ~~RESOLVED, That this resolution be immediately forwarded to the House of Delegates for consideration at the 2017 Interim Meeting (Directive to Action)~~	No action; already in Digest.
Late Resolution 1: Network Adequacy	RESOLVED, That our AMA-RFS recognize network adequacy as a central element of access to care; and be it	No action; already in Digest.

	further RESOLVED, That our AMA-RFS recognize that network adequacy must include emergency and psychiatric care; and be it further RESOLVED, That our AMA-RFS work with interested sections ~~and organizations~~ to ensure that out-of-network policies do not limit access to care by creating undue financial and administrative burdens for patients and physicians.	
Resolution 1: Regulating Tattoo and Permanent Makeup Inks	RESOLVED, That our AMA encourage the Food and Drug Administration (FDA) to adopt regulatory standards for tattoo and permanent makeup inks that include at minimum the disclosures expected for injectable drugs and cosmetics and mandate that this information be available to both the body licensed to perform the tattoo and to the person receiving the tattoo; and be it further RESOLVED, That our AMA study the safety of any chemical in tattoo and permanent makeup inks. ~~encourage the FDA to ban from tattoo and permanent makeup inks any chemical for which significant concern exists with regard to their carcinogenic, mutagenic, reprotoxic, and sensitizing properties~~.	No action; already in Digest.
Resolution 2: Prevention of Physician and Medical Student Suicide	RESOLVED, That our AMA request ~~recommend~~ that the Liaison Committee on Medical Education and Accreditation Council of Graduate Medical Education ~~investigate conditions and circumstances at~~ collect data on ~~any~~ medical ~~school~~ student, resident and fellow ~~residency program that has experienced a~~ suicides to identify patterns that could predict such events.	No action; already in Digest.
Resolution 5: The Intracranial Hemorrhage Anticoagulation Reversal (ICHAR) Initiative	~~RESOLVED, That the AMA-RFS support initiatives and legislation in the US Congress to promote the use of anticoagulation reversal medications up to date with the most current nationally recognized, evidence based stroke guidelines for patients with intracranial hemorrhage.~~ ~~RESOLVED, That the AMA-RFS support initiatives and legislation in the US Congress adding requirements for stroke centers and high-stroke volume hospitals to carry and use anticoagulation reversal agents or risk penalties determined by the appropriate supervising bodies.~~ RESOLVED, That that the AMA support ~~studying ways~~ initiatives to improve and reduce the barriers to the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening clinical indications.	No action; already in Digest.
Resolution 6: Setting Boundaries for Extending Residents' Training Beyond Traditional Residency Completion Dates	*Reaffirmed existing policy.*	No action; already in Digest.
Resolution 7: Clinical	~~RESOLVED, That our AMA strongly support the preservation~~	No action; already

Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows	~~of the incorporation of the clinical practice of pathology and laboratory medicine into integrated undergraduate and specialty tailored graduate medical education.~~ RESOLVED, That our AMA study current standards within medical education regarding pathology and laboratory medicine to identify potential gaps in training ~~in collaboration with other entities invested in medical education, provide educational resources, including guidelines for competencies in pathology and laboratory medicine for medical student, resident and fellow members~~.	in Digest.
Resolution 8: Evaluation of Changes to Residency and Fellowship Application and Matching Processes	~~RESOLVED, That our AMA and AMA-RFS support proposed changes to residency and fellowship application requirements only when those changes have been evaluated by working groups which have students and residents as representatives, there is data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, there is data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds, and the costs to medical students and residents are mitigated.~~ ~~RESOLVED, That it asks that our AMA and AMA-RFS oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met.~~ ~~RESOLVED, That it also asks that our AMA and AMA-RFS 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.~~ <u>RESOLVED, That our AMA and AMA-RFS</u> 1. <u>Support proposed changes to residency and fellowship application requirements only when</u> a. <u>Those changes have been evaluated by working groups which have students and residents as representatives</u> b. <u>There ~~is~~ are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate</u> c. <u>There ~~is~~ are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds</u> d. <u>The costs to medical students and residents are mitigated</u>	No action; already in Digest.

	2. Oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met 3. 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; and be it further ~~RESOLVED, That our AMA~~ ~~1. Support proposed changes to residency and fellowship application requirements only when~~ ~~a. Those changes have been evaluated by working groups which have students and residents as representatives~~ ~~b. There are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate~~ ~~c. There are data available to demonstrate that the new application requirements do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds~~ ~~d. The costs to medical students and residents are mitigated~~ ~~Oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met~~ ~~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~~	
Resolution 11: Residency Match Systems and Timelines	RESOLVED, That our AMA ~~RFS support the AMA to~~ work with all invested stakeholders, specialties and application systems in the residency match excluding the military match to support and ensure parity with the match timeline and the ability to couples match by moving towards a unified and standardized process. RESOLVED, That our AMA ~~RFS request the AMA to~~ work with all invested stakeholders to design a provisional match system whereby medical students matching into preliminary (PGY-1) and, separately, advanced (PGY-2) residency programs match through a staggered system so that the PGY-2 match is timed with the match for all categorical PGY-1 positions and the match for preliminary PGY-1 programs is subsequently delayed to allow for a reduction in application and travel costs with the SOAP to follow the staggered match.	No action; already in Digest.

	RESOLVED, That our AMA ~~RFS request the AMA to~~ support and encourage all match application systems to provide robust match data to their applicants. RESOLVED, That our AMA-RFS support working with all invested stakeholders, specialties and application systems in the residency match excluding the military match to support and ensure parity with the match timeline and the ability to couples match by moving towards a unified and standardized process. RESOLVED, That our AMA-RFS support working with all invested stakeholders to design a provisional match system whereby medical students matching into preliminary (PGY-1) and, separately, advanced (PGY-2) residency programs match through a staggered system so that the PGY-2 match is timed with the match for all categorical PGY-1 positions and the match for preliminary PGY-1 programs is subsequently delayed to allow for a reduction in application and travel costs with the SOAP to follow the staggered match. RESOLVED, That our AMA-RFS support and encourage all match application systems to provide robust match data to their applicants.	
Resolution 12: Improving Utility of Clinical Documentation	RESOLVED, That our AMA-RFS advocate that the appropriate ~~regulatory~~ institutions determine level of care and reimbursement based more on complexity of medical diagnoses and medical decision making rather than quantity of components in medical documentation.	No action; already in Digest.
Resolution 14: Support for the Income-Driven Repayment Plans	RESOLVED, That our AMA ~~collaborate with interested third party organizations to~~ advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden.	No action; already in Digest.
Resolution 15: Support for the Development and Distribution of HIPAA-compliant Communication Technologies	RESOLVED, That our AMA ~~advocate for~~ promote the development and use of HIPAA-compliant technologies for text messaging, electronic mail and video conferencing. ~~RESOLVED, That our AMA develop a database of existing HIPAA-compliant technologies to be made accessible to the medical community.~~	No action; already in Digest.
Report E: AMA-RFS Sunset Mechanism Procedure	RESOLVED, That our AMA-RFS Governing Council present actionable sunset recommendations to RFS policy via a yearly report at our Annual Meeting; and be it further RESOLVED, That each adopted resolve or recommendation clause within an RFS policy shall be considered individually with regard to the sunsetting process; and be it further RESOLVED, That our AMA-RFS annually review ten-year-old RFS policies and recommend whether to (a) reaffirm the policy, (b) rescind the policy, (c) reconcile the policy with more recent and like policy, or (d) make editorial changes which maintain the original intent of the policy; and be it further RESOLVED, That each RFS sunset recommendation	No action; speaks to IOP.

	regarding RFS policy may be extracted from the Consent Calendar and handled individually by our Assembly, but may only be adopted or not adopted; and be it further RESOLVED, That an action of the RFS Assembly that retains or updates an existing RFS policy shall reset the sunset "clock," making the reaffirmed RFS policy viable for ten additional years; and be it further RESOLVED, That defeated RFS sunset recommendations be reaffirmed for one year, to be readdressed via RFS Governing Council report or resolution from the RFS Assembly at or prior to the next RFS Annual Meeting; and be it further RESOLVED, That nothing in this policy shall prohibit a report or resolution to sunset an RFS policy earlier than its ten-year horizon if it is no longer relevant, has been superseded by a more current RFS policy, or has been accomplished; and be it further RESOLVED, That **580.013R Sunset of AMA-RFS Policy** be rescinded.	
	Annual 2018	
Emergency Resolution: Separation of Children from their Parents at Border	RESOLVED, That our AMA oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being; and be it further (New HOD Policy) RESOLVED, That our AMA urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families; and be it further (Directive to Take Action)	No action; already in Digest.
Resolution 1 - Naming Convention for AMA-RFS Policy Resolution 17 - Internal Operating Procedures Revision	RESOLVED, That our AMA-RFS will form an ad hoc committee ~~(Committee)~~ broadly representing the membership of the Assembly for the purpose of reviewing and revising the AMA-RFS IOPs with a progress report at I-18. ~~; and be it further~~ ~~RESOLVED, That our AMA-RFS will receive from the Governing Council at I-18 a comprehensive draft report from the Committee reviewing the IOPs and detailing proposed revisions thereto; and be it further~~ ~~RESOLVED, That the Governing Council will make the draft report available electronically to the membership of the AMA-RFS Assembly at least 42 days prior to I-18; and be it further~~ ~~RESOLVED, That our AMA-RFS will dedicate time during the I-18 business meeting for comment on the draft report and the proposed revisions to the IOPs; and be it further~~	Recommend reconciliation; if completed no action needed however no report in Summary of Actions I-18.

	~~RESOLVED, That our AMA-RFS will receive from the Governing Council at A-19 a final report from the Committee detailing final proposed revisions to the IOPs based on comment obtained at I-18; and be it further~~ ~~RESOLVED, That the Governing Council will make the final report available electronically to the membership of the AMA-RFS Assembly at least 2 months prior to A-19; and be it further~~ ~~RESOLVED, That our AMA-RFS Speaker call for a vote either to approve or to refer the final report of the Governing Council in the normal course of business at A-19, unless such order of business be modified by the will of the Assembly; and be it further~~ ~~RESOLVED, That our AMA-RFS Speaker may call for a vote to approve or refer individual bylaws or groups of bylaws using the discretion afforded by the Rules of Parliamentary Procedure to reflect the will of the RFS Assembly and to maintain internal consistency in the approved bylaws; and be it further~~ ~~RESOLVED, That the Governing Council will return with a revised report from the Committee addressing all referred items at each subsequent meeting during which a vote will be taken to either approve or refer the report as a whole or in part; and be it further~~ ~~RESOLVED, That our AMA-RFS follow normal operating procedure by submitting revised IOPs to the AMA for approval only after the RFS Assembly has approved a complete set of IOP revisions through this process; and be it further~~ ~~RESOLVED, That our AMA-RFS reconvene the Committee every 10 years to modify, as needed, our IOPs except as otherwise provided in future revisions of the IOPs.~~	
Resolution 2 - Comprehensive Breast Cancer Treatment	RESOLVED, That our AMA-RFS: (1) believes that reconstruction of the breast for rehabilitation of the post-treatment cancer patient with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided (New RFS Policy); and be it further	R1-R3: already in Digest R4: Add to Digest as internal policy.

	RESOLVED, That our AMA-RFS acknowledge that access to breast reconstruction is a pivotal part of the breast cancer care pathway (New RFS Policy); and be it further RESOLVED, That our AMA-RFS advocate that reconstructive techniques for partial mastectomy be covered to the same degree as reconstruction following complete mastectomy (New RFS Policy); and be it further RESOLVED, That our AMA amend Policy H-55.973 by addition and deletion as follows: Our AMA: (1) believes that reconstruction of the breast for rehabilitation of the ~~postmastectomy~~ post-treatment ~~cancer~~ patient with in situ or invasive breast neoplasm should be considered reconstructive surgery rather han aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; and (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided. (Amend HOD Policy)	
Resolution 3 - Mandating Critical Congenital Heart Defect Screening in Newborns	RESOLVED, That our AMA supports ~~mandated~~ screening for critical congenital heart defects ~~by pulse oximetry~~ for newborns following delivery prior to hospital discharge. (New HOD Policy)	No action; already in Digest.
Resolution 4 - Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients	RESOLVED, That our AMA encourage full disclosure to cancer patients on risks to fertility when gonadotoxicity due to cancer treatment is ~~unavoidable~~ a possibility (New RFS Policy); and be it further RESOLVED, That our AMA support ~~enhanced training of pediatric oncology fellows and reproductive endocrinology fellows in providing thorough counseling to oncology patients~~ education for providers who counsel patients ~~who~~ that may benefit from fertility preservation. (New RFS Policy)	No action; already in Digest.
Resolution 5- Removal of the Food and Drug Administration Risk Evaluation and Mitigation Strategy for Mifepristone Use in Early Pregnancy Failure	RESOLVED, That our AMA-RFS ~~encourage the FDA to remove~~ support the removal of the FDA Risk Evaluation and Mitigation Strategy for mifepristone in early pregnancy failure (Directive to Take Action); and be it further RESOLVED, That our AMA-RFS support ~~increase~~ education and training of practitioners who diagnose and are allowed to treat early pregnancy failure with mifepristone ~~rather than an inferior regimen~~. (New RFS Policy)	No action; already in Digest.
Resolution 6-Access to Care Restriction on	RESOLVED, That our AMA ~~RFS~~ advocate for changes to federal legislation allowing physicians with a J-1 visa in	No action; already in Digest.

IMG Moonlighting	fellowship training programs the ability to moonlight ~~bill Medicare and Medicaid~~ (Directive to Take Action)~~; and be it further~~ ~~RESOLVED, That this resolution be forwarded to the AMA House of Delegates at I-18. (Directive to Take Action)~~	
Resolution 8- Medical Technology and Artificial Intelligence: Regulation and Oversight Requirements by the Food and Drug Administration	RESOLVED, That our American Medical Association (AMA) work with the Food and Drug Administration (FDA) to ensure that warnings are issued when artificial intelligence and technological innovations, regarding human health, are used for purposes outside their intended FDA approved medical use by individuals that are not licensed medical professionals (Directive to Take Action); and be it further RESOLVED, That our AMA work with the FDA to restrict use of artificial intelligence and technological innovations in medicine and human health to be in consult with physicians and physician-led health care teams comprised of licensed medical professionals after verification of clinical applicability, safety, and accuracy. (Directive to Take Action)	No action; generated a report.
Resolution 9- Ownership and Sale of Medical Data	RESOLVED, That our ~~American Medical Association (AMA)~~ AMA-RFS support our AMA's development of model legislation concerning ownership of medical records (Directive to Take Action)	No action; already in Digest.
Resolution 10- Coordinating Correctional and Community Healthcare	RESOLVED, That our AMA support linkage of those incarcerated to community clinics upon release in order to accelerate ~~linkage~~ access to primary care and improve health outcomes among this vulnerable patient population, as well as adequate funding (Directive to Take Action); and be it further RESOLVED, That our AMA support the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. (Directive to Take Action)	No action; already in Digest.
Resolution 11- A Study to Evaluate Barriers to Medical ~~School Matriculation~~ Education for ~~Students~~ Trainees with Disabilities	~~RESOLVED, That our AMA and AMA-RFS partner with relevant stakeholders to increase outreach efforts directed at students with disabilities to support a culture of inclusion (Directive to Take Action); and be it further~~ RESOLVED, That our AMA ~~and AMA-RFS~~ work with relevant stakeholders to study available data on medical trainees with disabilities and consider revision of technical standards for medical ~~school admission~~ education programs. (Directive to Take Action)	No action; already in Digest.
Resolution 12- Support for Deferred Action Childhood Arrivals (DACA) Medical Students and Physicians	RESOLVED, That our AMA-RFS ~~re~~affirm support for the Deferred Action for Childhood Arrivals (DACA) for current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients (Directive to Take Action); and be it further RESOLVED, That the AMA-RFS continues supporting any legislation to protect DACA recipients. (Directive to Take Action)	No action; already in Digest.
Resolution 13-	RESOLVED, That our AMA-RFS defines resident and fellow	No action; already

Scholarly Activity by Resident and Fellow Physicians	scholarly activity as any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, national leadership positions within health policy organizations,local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity ~~resident or fellow experience that involves the discovery, integration, application, or teaching of knowledge .(New RFS Policy);~~ and be it further RESOLVED, That our AMA work with partner organizations to ensure that residents and fellows are able to fulfill scholarly activity requirements with any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to ~~for residents,fellows, and faculty are not restricted to only~~ peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity ~~and resident and fellow scholarly activity requirements can be fulfilled by the breadth of experiences permitted within faculty requirements.~~(Directive to Take Action)	in Digest.
Resolution 14-Investigation into Residents, Fellows, and Physician Unions	~~RESOLVED, That our AMA-RFS ask our AMA to support a change to internal policies and its stance on unions; and be it further~~ RESOLVED, That the AMA~~-RFS support and ask our AMA to support~~ study the feasibility of a national house-staff union to represent all interns, residents and fellows~~.; and be it further~~ ~~RESOLVED, That our AMA investigate, with internal resources, the possibility, feasibility, and advisability of the AMA in organizing and running a physician union that prohibits actions that affect patient care while collectively representing all physicians as a true union and present a report on its findings no later than the AMA Annual Meeting 2019; and be it further~~ ~~RESOLVED, That our AMA-RFS forward this resolution to the AMA House of Delegates at the 2018 Interim Meeting.~~	No action; already in Digest.
Resolution 16-Insurance Coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogram	RESOLVED, That our AMA support insurance coverage for supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician (Directive to Take Action); and be it further RESOLVED, That our AMA advocate for insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician. (Directive to Take Action)	No action; already in Digest.
	Interim 2018	

Late Resolution 1: Extending Pregnancy Medicaid To One Year Postpartum	RESOLVED, That our AMA petition CMS to extend pregnancy Medicaid to a minimum of one year postpartum.	No action; already in Digest.
Late Resolution 2: Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients	RESOLVED, That our AMA work with relevant stakeholders in developing sustainable plans for the appropriate discharge of chronically-homeless patients from hospitals; and be it further RESOLVED, That our AMA reaffirm H-270.962 and H-130.940; and be it further RESOLVED, That this resolution be immediately forwarded to the House of Delegates for consideration.	No action; already in Digest.
Late Resolution 3: Affirming the Medical Spectrum of Gender	RESOLVED, That our AMA-RFS support initiatives that educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and be it further RESOLVED, That our AMA-RFS affirm that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.	No action; already in Digest.
Resolution 1: Support for Medicare Disability Coverage of Contraception for Non Contraceptive Use	RESOLVED, That our AMA ~~RFS encourage~~ work with Center for Medicare and Medicaid Services and other stakeholders ~~CMS prescription benefit plans~~ to include coverage for all FDA-approved contraception, ~~including the levonorgestrel intrauterine device,~~ for non-contraceptive use for patients covered by Medicare ~~in patients covered by Medicare disability insurance.~~	No action; already in Digest.
Resolution 2: Support for Medicare Disability Coverage of Contraception for Women of Reproductive Age	RESOLVED, That our AMA-RFS encourage CMS to provide coverage for all FDA-approved contraception for reproductive aged women covered by Medicare disability insurance.	Add to Digest.
Resolution 3: Increasing Rural Rotations During Residency	RESOLVED, That our AMA work with state and specialty societies, medical schools, teaching hospitals, ACGME, CMS and other interested stakeholders to encourage and incentive qualified rural physicians to serve as preceptors, volunteer faculty, etc. for rural rotations in residency; and be it further RESOLVED, That our AMA work with ACGME, ABMS, FSMB, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas; and be it further resolved RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase residency training opportunities with a report back to the HOD and formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.	No action; already in Digest.

Resolution 4: Promoting Nutrition Education Among Healthcare Providers	AMA Policy H-465.988 be reaffirmed in lieu of Resolution 3.	Add to Digest as internal policy.
Resolution 5: DACA in GME	AMA Policies D-255.991 and D-350.986 be reaffirmed in lieu of Resolution 5.	No action; would not affect internal policy.
Resolution 6: Contraception for Incarcerated Women	~~RESOLVED, That our AMA supports access to contraceptive options for advocates for state and local health departments to work with correctional facilities to provide contraception to incarcerated women prior to release.; and be it further~~ RESOLVED, That our AMA supports incarcerated persons' access to evidence-based contraception counseling, access to all contraceptive methods and autonomy over contraceptive decision making prior to release. ~~RESOLVED, That our AMA encourage partnerships between healthcare providers and correctional care communities, including state and local health departments, correctional facilities and community healthcare centers, so that access to contraception among women recently released from correctional facilities may be increased; and be it further~~ ~~RESOLVED, That our AMA recognize that access to contraception is a serious healthcare concern among incarcerated women; and be it further~~ ~~RESOLVED, That our AMA petition the National Commission on Correctional Healthcare to recognize that access to contraception is a serious healthcare concern among incarcerated women.~~	No action; already in Digest.
Resolution 7: Decreasing Financial Burdens on Residents and Fellows	RESOLVED, That our AMA partner with the ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing subsidized access to day care facilities and other basic necessities such as on call meal allowances for residents taking in-house call, and free parking on site, and further be it RESOLVED, That this resolution be forwarded to AMA-HOD at A-19.	No action; referred for study.
Resolution 8: Strategies to Reduce Burnout in Medical Trainees	AMA-RFS policy 291.015R be reaffirmed in lieu of Resolution 8.	No action; already in Digest.
Resolution 9: Medical Aid in Dying	RESOLVED, That our AMA-RFS support changes to AMA policy to support laws that allow for Medical Aid in Dying; and be it further RESOLVED, That our AMA-RFS support changes to AMA policy to move the AMA towards public support of Medical Aid in Dying; and be it further RESOLVED, That our AMA-RFS support changes to AMA policy which codify that it is within the AMA's Code of Medical Ethics for physicians to involve Medical Aid in Dying in their	No action; referred for report.

	practice when allowed by law and agreed to by the patient and provider; and be it further RESOLVED, That our AMA-RFS work with appropriate external organizations to ensure that resident and fellow training includes training in Medical Aid in Dying as allowed by law and at the discretion of the trainee, and support policy changes within the AMA which seek to do the same; and be it further RESOLVED, That our AMA-RFS support the AMA in ending its practice of using the term "physician assisted suicide" and instead replace it with the term "Medical Aid in Dying."	
Resolution 10: Improving Patient Care Through Patient Self Awareness of Personal Health Information	RESOLVED, That our AMA-RFS ask our AMA to evaluate methods to garner patient responsibility to provide Protected Health Information (PHI) to their healthcare providers, and be it further RESOLVED, That our AMA-RFS ask our AMA to study the impact such methods may have on health outcomes.	No action; not adopted
Resolution 11: Delegation of Informed Consent	RESOLVED, That our AMA in cooperation with other relevant stakeholders advocate that a qualified physician be able to delegate his or her duty to obtain informed consent to another provider that has knowledge of the patient, the patient's condition, and the procedures to be performed on the patient. <u>RESOLVED, That our AMA study the implications of the Shinal v. Toms ruling and its potential effects on the informed consent process.</u>	No action; already in Digest.
	Annual 2019	
Emergency Resolution 1 – Interference with Practice of Medicine by the Nuclear Regulatory Commission	~~RESOLVED, That our AMA advocate for a follow-up review by the Institute of Medicine of the Nuclear Regulatory Commission's medical use program, specifically evaluating effects of the Nuclear Regulatory Commission's regulatory policy in the last 25 years on the current state of nuclear medicine in the U.S. and patients' access to care. (Directive to Action)~~ Our AMA will express its opposition to the imminent proposed changes to the Section 10 CFR Part 35.390(b) by the Nuclear Regulatory Commission (NRC) which would weaken the requirements for Authorized Users of Radiopharmaceuticals (AUs), including shortening the training and experience requirements, the use of alternative pathways for AUs, and expanding the use of non-physicians, with AMA advocacy for such opposition during the open comment period ending July 3, 2019.	Add to Digest.
Late Resolution 1 - AMA HOD Election Reform	RESOLVED, That the AMA-RFS support that the AMA create a speaker-appointed task force to re-examine election rules and logistics including regarding social media, emails, mailers, receptions and parties, ability of candidates from smaller delegations to compete, balloting electronically, and timing within the meeting, and to report back recommendations regarding election processes and procedures to accommodate improvements to allow delegates to focus their efforts and time on	No action; already in Digest.

	policy-making; and be it further RESOLVED, That AMA-RFS support that the AMA's speaker-appointed task force consideration should include addressing (favorably or unfavorably) the following ideas: a) SElections being held on the Sunday morning of the annual and interim meetings of the House of Delegates. b) SCoordination of a large format interview session on Saturday by the Speakers to allow interview of candidates by all interested delegations simultaneously. c) SSeparating the logistical election process based on the office (e.g. larger interview session for council candidates, more granular process for other offices) d) SAn easily accessible system allowing voting members to either opt in or opt out of receiving AMA approved forms of election materials from candidates with respect to email and physical mail. e) SElectronic balloting potentially using delegates' personal devices as an option for initial elections and runoffs in None; internal position statement 520.002R This document does not represent official policy of the American Medical Association (AMA). Refer to AMA PolicyFinder for official policy of the Association. 3 order to facilitate timely results and minimal interruptions to the business. f) SSeeking process and logistics suggestions and feedback from HOD caucus leaders, non-HOD physicians (potentially more objective and less influenced by current politics in the HOD), and other constituent groups with a stake in the election process.g) SAddress the propriety and/or recommended limits of the practice of delegates being directed on how to vote by other than their sponsoring society (e.g. vote trading, block voting, etc.); and be it further RESOLVED, That the AMA-RFS support that the task force report back to the HOD at the A-20 meeting.	
Resolution 1 - Improving Medical Clearance Policies for Cognitive Impairment Improving Medical Clearance Policies for Traumatic Brain Injury Patients	RESOLVED, That our AMA-RFS advocate for amending current federal and state laws to clearly include symptomatic TBI patients as prohibited from obtaining or retaining a license to carry a firearm until they are medical cleared; and be it further RESOLVED, That our AMA-RFS create policy, advocate for, and support any state legislation that expands medical clearance requirements and firearm purchasing restrictions to all individuals that have medical conditions likely to cause substantial impairment in judgment, mood, perception, impulse control, intellectual ability, possibly leading to harm of self or other, and who will require continuous medical treatment for any of these issues, or has been diagnosed by a licensed physician or declared by a	No action; already in Digest.

	~~court to be incompetent to manage his or her affairs; and be it further~~ ~~RESOLVED, That our AMA-RFS advocate for legislation focused on physician reporting of all patients with prohibitive conditions, including symptomatic TBI patients, to appropriate state oversight agencies relating to driving and/or gun use; and be it further~~ ~~RESOLVED, That our AMA-RFS advocate for physician-led committees in each state to give recommendations to the state regarding further driving and/or gun use by individuals who are cognitively impaired and/or a danger to themselves or others.~~ RESOLVED, That our AMA advocate for federal and state legislation that aides and eases the burden to report individuals with severe and/or concerning cognitive impairments with functional problems to appropriate boards and other authorities responsible for the public health, safety of the state relating to driving gun use; and be it further (referred) RESOLVED, That our AMA-RFS support advocacy for physician-led committees (i.e. medical advisory boards) in each state to give recommendations to the state regarding further driving and/or gun use by individuals who are cognitively impaired and possibly a danger to themselves or others, as stated in federal law 18 U.S.C. § 922(g)(4). (adopted)	
Resolution 2 - Decreasing the Use of Oximetry Monitors for The Prevention of Sudden Infant Death Syndrome ~~Decreasing Use of Non-FDA Regulated Oximetry Monitors in Infants~~	RESOLVED, That our AMA-RFS oppose the sale and use of ~~publish a policy statement condemning the use of commercial, non-FDA regulated~~ oximetry monitors to prevent sudden infant death syndrome. RESOLVED, That this resolution be forwarded to the House of Delegates at I-19.	No action; already in Digest.
Resolution 4- Supporting the Reclassification of Complex Rehabilitation Technology to Improve Access to Individuals with Substantially Disabling and Chronic Conditions	RESOLVED, That our AMA-RFS support reclassifying complex rehabilitation technology equipment into its own distinct payment category under the Centers for Medicare & Medicaid Services to improve access to individuals with substantially disabling and chronic conditions.	No action; already in Digest.

	RESOLVED, That our AMA-RFS support national and state efforts for allowing emancipated mature minors to give their own informed consent for vaccinations; and be it further RESOLVED, That Policy H-440.970, "Nonmedical Exemptions from Immunizations" be amended by deletion ~~addition~~ to read as follows: Our American Medical Association believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large. Therefore, our AMA (1) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (2) supports legislation eliminating nonmedical exemptions from immunization; (3) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (4) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (5) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (6) recommends that states have in place: (a) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (b) policies that permit immunization exemptions for medical reasons only.; ~~SUand~~ ~~(7) encourages states to allow mature minors to consent for CDC-recommended vaccinations if~~ ~~deemed by the physician as in their best interest;~~ ~~and be it further SRESOLVED, That this resolution be immediately~~ ~~forwarded to the House of Delegates at A-19.~~	R1: No action; already in Digest. R2: Add to Digest as internal policy.
Resolution 10—Residency and Fellowship Program Director, Assistant/Associate Program Director, and Core Faculty Protected Time and Salary Reimbursement	RESOLVED, That our AMA-RFS support amending 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 ~~Sof a given residency or fellowshipS Sand work with the ACGME and other relevant stakeholders to accomplish this goalS~~; and be it further RESOLVED, That our AMA work with the ACGME and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific	Add to Digest.

	ACGME program requirements enabling specialtiesU to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA HOD at SIS-SA-19.	
Resolution 12—Facilitating Physicians in Training Seeking Mental Health Care Through Physician Health Programs	RESOLVED, That our AMA amend the AMA Model Bill: Physician Health Programs Act, adding the definition of a "physicians in training" as a physician in an ACGME-accredited training program to Section 6. "Definitions"; and be it further RESOLVED, That our AMA amend the AMA Model Bill: Physician Health Programs Act, adding the following subsection within the section "Application to a PHP for voluntary assistance": "a physician in training who voluntarily requests participation in a PHP for a substance use disorder, mental health condition or other medical disease shall have his or her training program directly and actively involved in all stages of PHP assessment, treatment planning, enrollment, and monitoring"; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA HOD at A-19.	Recommend reconciliation; multiple proposed changes to this model legislation and unclear if should be included in Digest.
Report B—Internal Operating Procedures Renewal	[revised RFS IOPs submitted to Council on Constitution & Bylaws post-meeting]	No action; IOPs renewal.
Report C—Contraceptive Access	1. Our AMA-RFS support the continued use of public funding for affordable and accessible family planning services that are ~~financially and physically accessible~~ free of undue burden, in an effort to reduce the rates of unplanned pregnancies. 2. Our AMA-RFS support over-the-counter access to ~~oral~~ contraceptives ~~pills~~. 3. Our AMA-RFS support policies and any work the AMA does with other interested organizations to increase access to and awareness of over-the-counter emergency contraception (H75.985, D75,997). 4. Our AMA-RFS support affordable Long- Acting Reversible Contraception access for all patients, including those in the immediate postpartum period. 5. Our AMA-RFS support training and financial assistance for providers to offer Long- Acting Reversible Contraception.	No action; already in Digest.
Report D—Medical Aid in Dying	1. That our AMA-RFS support the AMA ending its practice of using the term "physician-assisted suicide" and instead replace it with "medical aid in dying"; 2. That our AMA-RFS support protections for physicians and patients who participate in medical aid-in-dying in states where it is legal; and	No action; already in Digest.

	3. That our AMA-RFS adopt a position of neutrality toward physician aid in dying.	
Report F—Decreasing Financial Burdens on Residents and Fellows	1. That our AMA include expanded information on employee benefits in the AMA FRIEDA database, such as, but not limited to: subsidized access to day care facilities, on call meal allowances for residents taking in-house call, and free parking on site.	Add to Digest.
Report G—Healthcare Coverage and Access Proposals 2019	~~1. SCoverage: SIdeal health plans should strive to achieve universal healthcare coverage. Therefore, the AMA-RFS supports proposals that increase access to healthcare coverage across all ages and income levels, do not discriminate or limit coverage based on pre-existing conditions, and encompass comprehensive coverage of routine healthcare needs of patients including women's health and reproductive services.~~ ~~2. SAffordability: SThe issue of affordability is critical in healthcare~~ ~~proposals. Healthcare plans should be affordable to people across the United States, and affordability should not hinder patients' access to care. Therefore, the AMA-RFS supports proposals that cap premiums and limit cost sharing to a reasonable level.~~ ~~3. SAccess: SPatients should be able to access providers that are best able to serve their medical needs. Therefore, the AMA-RFS supports proposals that include adequate networks of providers and physician-led healthcare teams.~~ 1. AMA-RFS supports proposals that increase access to healthcare coverage across all ages and income levels, do not discriminate or limit coverage based on pre-existing conditions, and encompass comprehensive coverage of routine healthcare needs of patients including women's health and reproductive services. 2. AMA-RFS supports proposals that cap premiums and limit cost sharing to a reasonable level. 3. AMA-RFS supports proposals that include adequate networks of providers and physician-led healthcare teams.	No action; already in Digest.
Report J—Drug Costs and Shortages	1. Our AMA-RFS support that the AMA advocate for legislative and regulatory mechanisms to ensure more affordable generic biosimilar access without placing undue burdens on drug innovation. 2. Our AMA-RFS support the repeal of the 1987 Safe Harbor exemption to the Anti-Kickback Statute for Group Purchasing Organizations (GPOs) and PBMs (Pharmacy Benefit Managers).	No action; already in Digest.
	Interim 2019	
Late Resolution 1 – Safe Supervision of Complex Radiation Oncology Therapeutic Procedures	RESOLVED, That our AMA advocate that radiation therapy services should be exempted from the Hospital Outpatient Prospective Payment System (HOPPS) rule requiring only general supervision of hospital therapeutic services; and be it further	Add to Digest.

	RESOLVED, That our AMA advocate that direct supervision of radiation therapy services by a physician trained in radiation oncology should be required by the Centers for Medicare and Medicaid Services; and be it further RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at I-19.	
Resolution 1 – Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure	RESOLVED, That our AMA study and provide recommendations on how the process of assisting orphaned ~~trainees~~ residents and fellows could be improved in the case of training hospital or training program closure, including: 1. The current processes by which a displaced resident or fellow may seek and secure an alternative training position; and 2. How CMS and other additional or supplemental GME funding is re-distributed, including but not limited to: a. The direct or indirect classification of ~~trainees~~ residents and fellows as financial assets and the implications thereof; and b. Transfer of ~~full versus partial funding for~~ training positions between institutions and the subsequent impact on ~~trainee~~ resident and fellow funding lines in the event of closure; and ~~be it further~~ c. Transfer of full versus partial funding for new training positions; and ~~be it further~~ d. e. Transfer of funding for orphaned ~~trainees~~ residents and fellows who switch specialties; and be it further RESOLVED, That our AMA work with the Centers on Medicare and Medicaid Services (CMS) to establish regulations which protect ~~trainees~~ residents and fellows impacted by program or hospital closure which may include recommendations for: 1. Notice by the training hospital ~~of filing~~ intending to file for bankruptcy within 30 days, to all residents and fellows ~~trainees~~ primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows ~~trainees~~ to find and obtain alternative training positions which minimize undue financial and professional consequences, including but not limited to the maintenance of specialty choice, length of training, initial expected time of graduation, location~~,~~ and reallocation of funding~~.~~, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed; 2. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution~~.~~;	R1: No action; recommended report. R2-4: Add to Digest.

	3. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and ~~be it further~~ 4. Protections against the discrimination of orphaned residents and fellows consistent with H-295.969; and be it further RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which ~~trainees in~~ orphaned ~~residencies~~ residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program; and be it further RESOLVED, That our AMA work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, the Centers for Medicare and Medicaid Services, and other relevant stakeholders to: ~~develop a mechanism by which orphaned residents and fellows can obtain new training positions.~~ 1. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions; and 2. Create a centralized, regulated process for orphaned residents and fellows to obtain new training positions; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at I-19.	
Resolution 4 – Breast-Implant-Associated Anaplastic Large Cell Lymphoma **Implant-Associated Anaplastic Large Cell Lymphoma**	RESOLVED, That our AMA support appropriate coverage of cancer diagnosis, treating surgery and other ~~adjuvant~~ systemic treatment options for ~~breast~~ implant-associated anaplastic large cell lymphoma.	Add to Digest.

Resolution 5-Resident and Fellow Access to Fertility Preservation	RESOLVED, That our AMA support education for residents and fellows regarding the natural course of female fertility in relation to the timing of medical education, and the option of fertility preservation and infertility treatment; and be it further RESOLVED, That our AMA ~~encourage~~ advocate inclusion of insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; and be it further RESOLVED, That our AMA support the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including the need to attend medical visits to complete the oocyte preservation process and to administer medications in a time-sensitive fashion.	Add to Digest.
Resolution 6-Establishing Minimum Standards for Parental Leave During Graduate Medical Education Training	RESOLVED, That our AMA support current efforts by ~~petition~~ the ACGME ~~and the~~, American Board of Medical Specialties (ABMS), and other relevant stakeholders to develop and implement minimum requirements for parental leave during residency and fellowship training and urge these bodies to adopt minimum requirements in accordance with policy H 405.960; and be it further RESOLVED, That our AMA petition ACGME to recommend strategies to prevent undue burden on trainees related to parental leave. RESOLVED, That our AMA petition the ACGME ~~and the~~, ABMS, and other relevant stakeholders to develop specialty specific pathways for residents and fellows ~~trainees~~ in good standing, who take maximum allowable parental leave, to complete their ~~residency or fellowship~~ training within the original time frame.	Add to Digest.
Resolution 7—Ensuring Consent for Educational Physical Exams on Anesthetized and Unconscious Patients	RESOLVED, That our AMA oppose performing ~~educational~~ physical exams on patients under anesthesia or on unconscious patients that offer the patient no personal benefit and are performed solely for teaching purposes without prior ~~explicit~~ informed consent to do so; and be it further ~~RESOLVED, That our AMA encourage institutions to review alignment of their current practices with published guidelines, recommendations, and policies with respect to informing patients about educational physical exams performed under anesthesia or when unconscious and obtaining explicit informed consent to do so; and be it further~~ RESOLVED, That our AMA encourage institutions to align current practices with published guidelines, recommendations, and policies to ensure patients are educated on pelvic, genitourinary, and rectal exams that occur under anesthesia; and be it further RESOLVED, That our AMA strongly oppose issuing blanket bans on student participation in educational physical exams; and be it further	R1, R3, R4: Add to Digest. R2: No action; not adopted. R5: Add to Digest as internal policy.

	RESOLVED, That our AMA reaffirm policy H-320.951.	
Resolution 8—Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance	RESOLVED, That our AMA ~~-RFS~~ recognizes the importance of providing avenues for affordable health insurance coverage and health care access to patients who do not have employer-sponsored health insurance, or for whom employer-sponsored health insurance does not meet their needs; and be it further RESOLVED, That our AMA ~~-RFS~~ recognizes that a significant and increasing proportion of patients are unable to meet their health insurance or health care access needs through employer-sponsored health insurance, and that these patients must be considered in the course of ongoing efforts to reform the healthcare system in pursuit of universal health insurance coverage and health care access.	Add to Digest.
Resolution 9—E-Cigarette and Vaping Associated Illness	RESOLVED, That our AMA advocate for diagnostic coding systems including the ICD codes to have a mechanism to release emergency codes for emergent diseases; and be it further RESOLVED, That our AMA advocate for creation and release of ~~the addition of~~ ICD~~-10-CM~~ codes to include appropriate diagnosis codes for both the use of and toxicity related to e-cigarettes and vaping, including pulmonary toxicity; and be it further ~~RESOLVED, That our AMA supports banning flavored e-cigarettes products; and be it further~~ RESOLVED, That this resolution be immediately forwarded to the House of Delegates at I-19.	Add to Digest.
Resolution 10—Removing Sex Designation from the Public Portion of the Birth Certificate	RESOLVED, That our AMA-RFS advocate for the removal of "sex" as a designation on the public portion of the birth certificate, and that it be visible for medical and statistical use only.	No action; already in Digest.
Resolution 11—Studying Physician Supervision of Allied Health Professionals Outside Their Fields of Graduate Medical Education	RESOLVED, That our AMA conduct ~~support~~ a systematic study to collect and analyze publicly available physician supervision data from all sources to determine how many allied health professionals are being supervised by physicians in fields which are not a core part of those physicians' completed residencies and fellowships.	No action; request for report.
Report A—Matched Medical Students	*Recommendation 1:* Your AMA-RFS Governing Council recommends the following changes to the "American Medical Association Resident and Fellow Section Internal Operating Procedures" by addition as follows: **V. Elections** B. **Eligibility.** All members of the RFS are eligible for elected positions and endorsements. Medical	No action; forwarded to CCB for IOP change in Dec 2019.

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

Recommendation 2:

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

IX. Business Meeting

A. Other Representatives to the Business Meeting.

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

Recommendation 3:

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

IX. **Business Meeting**

F. Participation.

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

Recommendation 4:

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

E. Credentialing. The names of the duly selected voting RFS Business Meeting Delegates and Alternate Delegates from each state and specialty society should be received, in writing, by the Director of Resident and Fellow Services of the AMA at least 45 days prior to the start of the Business Meeting. Prior to the start of business on each day of the Business Meeting, credentialing will take place, where each voting member must officially identify themself to the Credentials Committee as having been duly selected to represent their state society, specialty society, or branch of the armed services. Those being credentialed must be (i) members of the RFS or (ii) medical students with AMA membership who have secured a residency position, signed a contract, and will be starting residency within 45 days of the Business Meeting and have secured an endorsement from a representative organization.

1. Registered RFS members or medical students with AMA membership who have secured a residency position, signed a contract, and will be starting residency within 45 days whose clinical responsibilities and travel arrangements require them to arrive during a day's business but after the close of credentialing may, at least four weeks prior to the Business Meeting, petition the Governing Council to be allowed to credential late for the meeting. The decision to allow an RFS member to credential late will be made by majority vote of the Speaker, Vice Speaker, Delegate, Alternate Delegate, and Chair of the Rules Committee with such vote being communicated to the RFS member and the Credentialing Committee, in writing, at least two weeks prior to the start of the meeting.
2. Previously registered RFS members who miss credentialing due to unforeseeable travel delays

	may, on a case-by-case basis, be allowed to credential late for that day's business. This would be determined by a majority vote of the Speaker, Vice Speaker, and Chair of the Rules Committee, and communicated to the RFS member and the remainder of the Credentialing Committee. 3. Only credentialed RFS ~~members~~ delegates present in the Business Meeting room may vote on items of business being considered.	
Report B—AMA Resident/Fellow Councilor Term Limits	*Recommendation 1:* That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows: **6.5 Council on Ethical and Judicial Affairs.** **6.5.7 Term.** **6.5.7.2** Except as provided in Bylaw 6.11, the resident/fellow physician member of the Council shall be elected for a term of 2~~3~~ years provided that if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. **6.5.8 Tenure.** Members of the Council may serve only one term, except that the resident/fellow physician member shall be eligible to serve for 3 terms and the medical student member shall be eligible to serve for 2 terms. A member elected to serve an unexpired term shall not be regarded as having served a term unless such member has served at least half of the term. **6.5.9 Vacancies.** **6.5.9.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of the Council ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates at the next Annual Meeting, on nomination by the President, for a 2~~3~~-year term. *Recommendation 2:* That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows: **6.6 Council on Long Range Planning and Development.** **6.6.3 Term.** **6.6.3.2 Resident/Fellow Physician Member.** The resident/fellow physician member of the Council shall be appointed for a term of 2~~3~~ years beginning at the conclusion of the Annual Meeting provided that if the resident/fellow physician member	No action; forwarded to CCB for Bylaws change in Dec. 2019 BOT.

	ceases to be a resident/fellow physician at any time prior to the expiration of the term for which appointed except as provided in Bylaw 6.11, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. **6.6.5 Vacancies.** **6.6.5.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of the Council ceases to complete the term for which appointed, the remainder of the term shall be deemed to have expired. The successor shall be appointed by the Speaker of the House of Delegates for a 2~~3~~-year term. *Recommendation 3:* That our AMA amend the AMA "Constitution and Bylaws" by addition and deletion to read as follows: **6.9 Term and Tenure - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health.** **6.9.1 Term.** **6.9.1.2 Resident/Fellow Physician Member.** The resident/fellow physician member of these Councils shall be elected for a term of 2~~3~~ years. Except as provided in Bylaw 6.11, if the resident/fellow physician member ceases to be a resident/fellow physician at any time prior to the expiration of the term for which elected, the service of such resident/fellow physician member on the Council shall thereupon terminate, and the position shall be declared vacant. **6.9.3 Vacancies.** **6.9.3.2 Resident/Fellow Physician Member.** If the resident/fellow physician member of these Councils ceases to complete the term for which elected, the remainder of the term shall be deemed to have expired. The successor shall be elected by the House of Delegates for a 2~~3~~-year term.	
	Annual 2020	
	Meeting was canceled given COVID-19 outbreak.	
	Interim 2020	
Report A—AMA-RFS Sunset Mechanism (2011)	Text not provided in Summary of Actions.	No action; would not affect internal policy.

Report B—AMA-RFS Sunset Mechanism (2008-2010)	Text not provided in Summary of Actions.	No action; would not affect internal policy.
Report C—Sectional Delegate Allotment	RFS Internal Operating Procedures (IOPs) VII. Sectional Delegates and Alternate Delegates to the House of Delegates E. Limitations 1. There shall be a limit of ~~one~~ two Sectional Delegates and ~~one~~ two Sectional Alternate Delegates per state or specialty society in the AMA House of Delegates.	No action; change in IOP
Report D—Decreasing Financial Burdens on Residents and Fellows	RESOLVED, That our AMA work with relevant stakeholders to ensure that medical trainees have access to on-site and subsidized childcare (Directive to Take Action); and be it further RESOLVED, That our American Medical Association work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to advocate for additional ways to defray costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties (Directive to Take Action); and be it further RESOLVED, That our AMA work with relevant stakeholders to define "access to food" for medical trainees to include overnight access to fresh food and healthy meal options within all training hospitals (Directive to Take Action); and be it further RESOLVED, That the Residents and Fellows' Bill of Rights be prominently published online on the AMA website and be disseminated to residency and fellowship programs (Directive to Take Action); and be it further RESOLVED, That the AMA Policy H-310.912, "Residents and Fellows' Bill of Rights," be amended by addition and deletion to read as follows: 5. Our AMA partner with ACGME and other relevant stakeholders to encourage~~s~~ training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services ~~teaching institutions to explore benefits to residents and fellows that will reduce personal cost of living expenditures, such as allowances for housing, childcare, and transportation~~. (Modify Current HOD Policy).	R1-R4: Add to Digest. R5: Add to Digest as internal policy.
Report E—Traumatic Brain Injury and Access to Firearms	1) That our AMA reaffirm policy H-145.972 "Firearms and High-Risk Individuals." 2) That our AMA amend policy H-145.975 "Firearm Safety and Research, Reduction in Firearm Violence, and	Add to Digest as internal policy.

	Enhancing Access to Mental Health Care" by addition and deletion to read as follows: 2. Our AMA supports initiatives designed to enhance access to the comprehensive assessment and treatment of mental health and substance use disorders in patients with ~~cognitive health care, with greater focus on the diagnosis and management of~~ traumatic brain injury~~y~~ies. ~~mental illness and concurrent substance use disorders,~~. ~~and~~ 3. Our AMA work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to evaluate the risk of potential violent behavior in patients with traumatic brain injury~~y~~ies. ~~and mental health assessment for potential violent behavior.~~ ~~3.~~ 4. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.	
Report G—Facilitating Physicians in Training Seeking Mental Health Care Through Physician Health Programs	1) That our AMA-RFS Governing Council propose amendments (as indicated above) to the AMA Advocacy Resource Center regarding the AMA Model Bill: Physician Health Programs Act, to include changing the definition of "physicians in training" in Section 6. "Definitions" to be: (1) medical students in medical schools accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA), (2) residents in training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), or (3) fellows in ACGME or non-ACGME accredited training programs. 2) That our AMA-RFS Governing Council propose amendments (as indicated above) to the AMA Advocacy Resource Center regarding the AMA Model Bill: Physician Health Programs Act, to include changing the following subsection within the section "Application to a PHP for voluntary assistance" to read: "a physician in training who voluntarily requests participation in a PHP for a substance use disorder, mental health condition or other medical disease shall, only if they desire, have their medical school or training program involved any stage of PHP assessment, treatment planning, enrollment, and monitoring." 3) That the AMA-RFS Governing Council report back the outcome of these actions to the AMA-RFS assembly at A-21. **Subsequent language in A-21**	Recommend reconciliation; multiple proposed changes to this model legislation and unclear if should be included in Digest.

	. That our AMA work with the ACGME~~, AOA,~~ and other relevant stakeholders to ensure physician health programs (PHPs) are promoted by training programs and transparent information is disseminated by programs to their trainees about PHP reporting requirements, benefits of participation, and limitations of such programs; and be it further ~~5~~ 2. That our AMA recognize PHPs ~~physician health programs~~ as one of many resources available to support physician trainee mental health.	
Report H—Pharmaceutical Advertising in Electronic Health Record Systems	1) That our AMA-RFS oppose medical education institutions and teaching hospitals accepting pharmaceutical and device advertising in EHRs.	No action; already in Digest.
	Annual 2021	
Resolution 1—Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use	RESOLVED, That our AMA oppose mandatory use of gonad shields in medical imaging considering the risks far outweigh the benefits; and be it further RESOLVED, That our AMA advocate that the FDA amend the code of federal regulations to oppose the routine use of gonad shields in medical imaging; and be it further RESOLVED, That our AMA, in conjunction with state medical societies, support model state and national legislation to oppose or repeal mandatory use of gonad shields in medical imaging.	Add to Digest.
Resolution 2—Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent	RESOLVED, That our AMA add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA demographics forms; and be it further ~~RESOLVED, That our AMA advocate for the use of "Middle Eastern/North African (MENA)" as a separate demographic identifier in all medical records; and be it further~~ ~~RESOLVED, That our AMA work with relevant stakeholders to promote the inclusion of "Middle Eastern/North African (MENA)" as a demographic identifying category in the U.S. Census and for all federally-funded research using racial/ethnic categories.~~ RESOLVED, That our AMA advocate for the use of "Middle Eastern/North African (MENA)" as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education.	Add to Digest.
Resolution 4—Opposition to Mid-level Provider Bias Against Physicians and Physician-Led Care	THE IMPACT OF MIDLEVEL PROVIDERS ON MEDICAL EDUCATION RESOLVED, That our AMA study, using surveys among other tools that protect identities, how commonly bias against physician-led healthcare is experienced within undergraduate	Add to Digest.

Resolution 5—Non-Physician Continued Education, Specialty and Subspecialty Training	medical education and graduate medical education, interprofessional learning and team building work and publish these findings in peer-reviewed journals ~~methods to regulate and ensure non-physician post-graduate education is rigorous and adequate to maintain the ability to practice within the intended field of practice with physician oversight~~; and be it further RESOLVED, That our AMA work with the LCME and ACGME to ensure all physician undergraduate and graduate training programs recognize and teach physicians that they are the leaders of the healthcare team and are adequately equipped to diagnose and treat patients independently only because of the intensive, regulated and standardized education they receive; and be it further RESOLVED, That our AMA study the harms and benefits of establishing mandatory postgraduate clinical training for Nurse Practitioners and Physician Assistants prior to working within a specialty or subspecialty field; and be it further RESOLVED, That our AMA study the harms and benefits of establishing national requirements for structured and regulated continued education for Nurse Practitioners and Physician Assistants in order to maintain licensure to practice.	
Resolution 6—Preserving Appropriate Physician Supervision of Midlevel Providers and Ensuring Patient Awareness of the Qualifications of Physicians vs. Midlevel Providers	RESOLVED, That our AMA reaffirm policies H-160.947 and H-160.950 ~~advocate that midlevel providers practicing independently without physician supervision be required to obtain informed consent from patients acknowledging and understanding that they are not being treated by a physician~~; and be it further RESOLVED, That our AMA work with relevant regulatory agencies to ensure physicians are notified in writing when their license is being used to “supervise” midlevel providers; and be it further ~~RESOLVED, That our AMA advocate for the appropriate supervision of midlevel providers by physicians as opposed to “collaboration,” which falsely equates non-physician training to that of physicians; and be it further~~ RESOLVED, That our AMA oppose mandatory physician supervision of midlevel providers as a condition for physician employment and in physician employment contracts, especially when physicians are not provided adequate resources and time for this responsibility; and be it further RESOLVED, That our AMA advocate for the right of physicians to deny “supervision” to any midlevel provider whom they deem a danger to patient safety and the ability to report unsafe care provided by mid-levels to the appropriate regulatory board with whistleblower protections for physician employment.	R1: Add to Digest as internal policy. R2, R4, R5: Add to Digest.

Resolution 7—Physician Opposition to the Coordinated Effort by Corporations and Midlevel Providers to Undermine the Physician-Patient Relationship and Safe Quality Care	~~RESOLVED, That our AMA acknowledge that the corporate practice of medicine has led to diminished quality of patient care, erosion of the physician-patient relationship, erosion of physician-driven care, physician burnout, and created a conflict of interest between profit and training the next generation of physicians needed for our nations physician shortage; and be it further~~ RESOLVED, That our AMA study the impact that individual physician scope of practice advocacy has had on physician employment and contract terminations ~~work with relevant stakeholders to support and provide legal resources to physicians who are terminated from employment for speaking out about scope of practice issues~~; and be it further RESOLVED, That our AMA study the views of patients on physician and non-physician care to identify best practices in educating the general population on the value of physician-led care ~~lead a national campaign to educate patients on the value of physician-led care and about the Dunning-Kruger effect in order to combat the false campaigns by midlevel providers/non-physicians~~; and be it further RESOLVED, That our AMA study the utility of ~~work with relevant stakeholders to create~~ a physician-reported database to track and report institutions that replace physicians with midlevel providers ~~and develop a platform~~ in order to aid patients in seeking physician-led medical care as opposed to care by midlevel providers practicing without physician supervision.	Add to Digest.
Resolution 9—The Impact of Private Equity on Medical Training	RESOLVED, That our AMA work with relevant stakeholders including specialty societies and the ACGME to study the level of financial involvement and influence ~~on medical practice and education of~~ private equity firms have in graduate medical education training programs and report back at I-21 with concurrent publication of their findings in a peer-reviewed journal; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the June 2021 Special Meeting of the HOD.	Add to Digest.
Resolution 10—Reducing Overall Fees and Making Costs for Licensing, Exam Fees, Application Fees, etc. Equitable for IMGs	RESOLVED, That our AMA work with ~~the ACGME, NBME, ECFMG, FSMB, and other~~ all relevant stakeholders to reduce application, exam, licensing fees and related financial burdens for IMGs to ensure cost equity with US MD and DO trainees. RESOLVED, that our AMA amend current policy H-255.966 "Abolish Discrimination in Licensure of IMGs" by addition to read as follows: "2. Our AMA will continue to work with the Federation of State Medical Boards to encourage parity in licensure requirements, and associated costs, for all physicians, whether U.S. medical school graduates or international medical graduates."	R1: Add to Digest. R2: Add to Digest as internal policy.

Resolution 11—Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education	RESOLVED, That our American Medical Association advocate to the Liaison Committee on Medical Education and other relevant stakeholders for the incorporation of Osteopathic Manual Therapy into the education curriculum of allopathic schools in the United States; and be it further RESOLVED, That our AMA advocate to the Accreditation Council for Graduate Medical Education and other relevant stakeholders for the incorporation of Osteopathic Manual Therapy into the education curriculum of all primary care residency training programs in the United States; and be it further RESOLVED, That our AMA continue to support equal treatment of osteopathic students, trainees and physicians in the residency application cycle and workplace through continued education on the training of Osteopathic physicians.	No action; generated a report.
Resolution 12—Addressing Gaps in Patient and Provider Knowledge to Increase HPV Vaccine Uptake and Prevent HPV-Associated Oropharyngeal Cancer	RESOLVED, That our AMA amend current policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by addition and deletion to read as follows: 1. Our AMA (a) urges physicians to educate themselves and their patients about <u>all</u> HPV<u>-mediated</u> ~~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 <u>all</u> HPV<u>-mediated</u> ~~and associated~~ diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public. 3. Our AMA (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination. 4. <u>Our AMA supports efforts (a) to enhance awareness in the general public regarding the association between HPV infection and oropharyngeal squamous cell carcinoma, and (b)</u>	Add to Digest as internal policy.

	to further develop oropharyngeal squamous cell carcinoma screening tools. RESOLVED, That our AMA amend current policy H-440.872 "HPV Vaccine and Cervical Cancer Prevention Worldwide" by title change to "HPV Vaccine and ~~Cervical~~ HPV-mediated Cancer Prevention Worldwide"; and be it further RESOLVED, That our AMA reaffirm policies D-170.995 "Human Papillomavirus (HPV) Inclusion in our School Education Curricula" and D-440.955 "Insurance Coverage for HPV Vaccine."	
Resolution 13—COVID-19 Vaccination Rollout to Emergency Departments and Urgent Cares	RESOLVED, That our AMA acknowledge that our nation's COVID-19 vaccine rollout is not yet optimized, and we have a duty to vaccinate as many people in an effective manner; and be it further RESOLVED, That our AMA work with other relevant organizations and stakeholders to lobby the current Administration for the distribution of COVID-19 vaccinations to our nation's emergency departments and urgent ~~cares~~ care facilities; and be it further RESOLVED, That our AMA advocate for additional funding to be directed towards increasing COVID-19 vaccine ambassador programs in emergency departments and urgent care facilities; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the June 2021 Special Meeting of the HOD.	Add to Digest.
Resolution 14—Expanding the AMA's Study on the Economic Impact of COVID-19	RESOLVED, That our AMA work with relevant organizations and stakeholders to study the economic impact and long-term recovery of the COVID-19 pandemic on healthcare institutions in order to identify and better understand which groups of physicians, patients and organizations may have been disproportionately affected by the financial burdens of the COVID-19 pandemic; and be it further RESOLVED, that our AMA work with relevant organizations and stakeholders to study the overall economic impact of office closures, cancellations of elective surgeries and interruptions in patient care, as well as the economic impact of utilizing telemedicine for an increasing percentage of patient care.	Add to Digest.
Resolution 15—Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis	~~RESOLVED, that our AMA advocate at all levels of government for equitable policies to transition rapidly away from the use of coal, oil and natural gas to clean, safe, and renewable energy and energy efficiency; and be it further~~ RESOLVED, that our AMA reaffirm policy H-135.949 "Support of Clean Air and Reduction in Power Plant Emissions"; and be it further RESOLVED, that our AMA establish a climate crisis campaign that will distribute evidence-based information on the relationship between climate change and human health,	R2: Add to Digest as internal policy. R3: Add to Digest.

	determine high-yield advocacy and leadership opportunities for physicians, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon ~~create an appropriate climate health crisis-focused longitudinal body or center for the purpose of determining the highest-yield advocacy leadership opportunities for our AMA in this public health crisis and for coordinating, strengthening and centralizing efforts toward advocating for an equitable and inclusive transition to a climate-neutral~~ society by 2050.	
Resolution 16— Accountable Organizations to Resident and Fellow Trainees	RESOLVED, That our AMA work with relevant stakeholders to: (1) determine which organizations or governmental entities are best suited for being permanently responsible for resident and fellow interests without conflicts of interests; (2) determine how organizations can be held accountable for fulfilling their duties to protect the rights and wellbeing of resident and fellow trainees as detailed in the Residents and Fellows' Bill of Rights; (3) determine methods of advocating for residents and fellows that are timely and effective without jeopardizing trainees' current and future employability; (4) study and report back by A-22 on how such an organization may be created, in the event that no organizations or entities are identified that meet the above criteria; and (5) determine transparent methods to communicate available residency positions to displaced residents.	Add to Digest.
	Interim 2021	
Report A— AMA- RFS Sunset Mechanism (2011)	The Sunset Mechanism 2011 RFS Positions contains a list of recommended actions regarding internal position statements last reviewed from the RFS 2011 fiscal year, as well as other relevant or associated outdated positions. Positions considered outmoded, irrelevant, duplicative, and inconsistent with more current positions will have specific recommendations. For each internal position statement under review, this sunset report recommends to: (1) rescind, (2) reaffirm, (3) reconcile with more recent actions, or (4) reaffirm with editorial changes, which constitutes a first order motion.	No action; will not affect internal policy.
Resolution 1— Bereavement Leave for Medical Students and Physicians	RESOLVED, That our AMA supports ~~adopts as policy the following guidelines for, and encourages the implementation of,~~ 'Bereavement Leave for Medical Students and Physicians': 1) Our AMA urges medical schools, residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of bereavement leave policies as part of the physician's standard benefit agreement. 2) Recommended components of bereavement leave policies for medical students and physicians include: ~~a) policy and duration of leave for the death of close family members, extended family members, close friends, and associates;~~ ~~b) definitions of those qualifying as close family members and extended family members;~~	No action; already in Digest

	~~c)~~ a) whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days; ~~d)~~ b) policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility; ~~e)~~ c) whether leave is paid or unpaid; ~~f)~~ d) whether obligations and time must be made up; and ~~g)~~ e) whether make-up time will be paid. 3) Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies, and medical group practices to incorporate into their bereavement leave policies a three-day minimum leave ~~allowance for the death of close family members and events of reproductive loss~~, with the understanding that no physician or medical student should be required to take minimum leave. 4) Medical students and physicians who are unable to work beyond the defined bereavement leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution's sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons. 5) Our AMA ~~endorses~~ supports the concept of equal bereavement leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity. 6) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs. 7) These guidelines ~~policies~~ as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship.	
Resolution 2—Solicitation of the AMA Brand	RESOLVED, that our AMA ~~create a task force to~~ study ~~and report back on~~ the use of AMA branded solicitation material mailed to physicians, the impact it has on the perception of our AMA by current and potential physician members, and the merits of continuing to use these materials in future communications; and be it further RESOLVED, that our AMA study our membership on the preferred method to receive third party solicitation material (mail, phone, email, social media) and provide a method to opt-out of certain methods if not desired.	No action; already in Digest
Resolution 3—Transparency of Resolution Fiscal Notes	TRANSPARENCY OF RESOLUTION AND REPORT FISCAL NOTES	No action; already in Digest

	RESOLVED, That our AMA amend current policy G-600.061 by addition and deletion to read as follows: "(d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of ~~the~~ any proposed ~~policy, program,~~ study or directive to take action shall be generated and published by AMA staff in consultation with the sponsor. prior to its acceptance as business of the AMA House of Delegates. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in the AMA House of Delegates Handbook to justify each fiscal note~~. When the resolution or report is estimated to have a resource implication of $50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers~~ (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes ~~policies, programs,~~ studies or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy."	
Resolution 4— Shortage of Bedside Nurses, Nurse Practitioner "Diploma Mills" and the Effects on Patient Safety and Quality Care	RESOLVED, That our AMA create a national campaign aimed at educating the population and state legislatures about the shortage of bedside nurses resulting from the push to create more nurse practitioners by "diploma mills"; and be it further RESOLVED, That our AMA oppose the expansion of nurse practitioner educational programs at the cost of exacerbating a shortage of bedside nurses and diverting resources from physician education; and be it further RESOLVED, That our AMA work with relevant stakeholders to push for standardized in-person clinical training in current nurse practitioner programs to curtail the poor training practices of nurse practitioner "diploma mills."	Recommend reconciliation; referred for Annual 2022, however not in Annual 2022 Summary of Actions (and not in AMA policy).
Resolution 5— Preserving Physician Leadership in Patient Care	RESOLVED, That our AMA work with relevant stakeholders to ~~conduct~~ commission an independent study comparing medical care provided by physician-led health care teams versus care provided by unsupervised non- physician ~~mid-level~~ providers, reporting on ~~practicing independently with regard to~~ quality of health outcomes, cost and cost effectiveness, and access to necessary medical care, and publish the findings in a peer-reviewed medical journal ~~such as JAMA~~; and be it further RESOLVED, That our AMA oppose physicians being referred to as "providers" in all healthcare settings; and be it further RESOLVED, That our AMA supports that National Physicians Week and National Doctors' Day be reserved solely for recognizing physicians.	No action; already in Digest

Resolution 6—Amend AMA Policy H-215.981 Corporate Practice of Medicine	RESOLVED, That our AMA amend policy H-215.981 Corporate Practice of Medicine by addition: 4. Our AMA acknowledges that the corporate practice of medicine has led to ~~diminished quality of patient care~~, erosion of the physician-patient relationship, erosion of physician-driven care, ~~physician burnout~~, and created a conflict of interest between profit and training the next generation of physicians ~~needed for our nation's physician shortage.~~	No action; already in Digest
Resolution 7—Comparing Student debt Earnings, Work Hours, and Career Satisfaction Metrics in Physicians	RESOLVED, That our AMA, ~~in order to better inform our advocacy efforts to preserve and improve physician-led care~~, study student debt, earnings, work hours, and job satisfaction metrics, including but not limited to burnout and work/life balance for MD and DO physicians as compared to other health professionals, such as physician assistants and nurse practitioners, and publish these findings in a peer reviewed journal, such as JAMA.	Add to Digest
Resolution 8—Medicare Coverage of Dental, Vision, and Hearing Services	RESOLVED, That our AMA support new Medicare funding that is independent of the physician fee schedule for coverage of: (1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; and (2) routine eye examinations and visual aids, including eyeglasses; and be it further RESOLVED, That our AMA amend Hearing Aid Coverage H-185.929 by addition as follows: 1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids. 2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear. 3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services. 4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team, aural rehabilitative services, and hearing aids as part of Medicare's Benefit. 5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.	No action: already in Digest

	6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids. 7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the November 2021 Special Meeting.	
Resolution 9—Sunset of the Interim Meeting Focus Requirement and the Resolutions Committee	DISSOLUTION OF THE RESOLUTION COMMITTEE RESOLVED, That our American Medical Association remove the Interim Meeting focus requirement by amending the AMA Bylaws B-2.12.1.1 “Business of Interim Meeting,” as follows by deletion: ~~2.12.1.1 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.;~~ and be it further RESOLVED, That our AMA dissolve the Resolution Committee by amending the AMA Bylaws B-2.13.3, “Resolution Committee,” as follows by deletion: ~~Resolution Committee. B-2.13.3 The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~ ~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~ ~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~ ~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~ ~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~ ~~2.13.3.5 Meetings. The committee shall not be required to hold meetings. Action may be taken by written or electronic communications.~~	Add to Digest as internal policy.

	~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim Meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~ ~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of the Speaker.~~ RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the November 2021 Special Meeting.	
Resolution 10—Recognition of National Anti-Lynching Legislation as Public Health Initiative	RESOLVED, That our AMA supports national legislation that recognizes lynching and mob violence towards an individual or group of individuals as a hate crimes; and be it further RESOLVED, That our AMA work with relevant stakeholders to support medical students, trainees, and physicians receiving education on the inter-generational health outcomes related to lynching and its impact on the health of vulnerable populations; and be it further RESOLVED, That current AMA policy H-65.965, “Support of Human Rights and Freedom” be amended by addition: Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, phenotypic appearance, religion, ~~political affiliation~~, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.; ~~(5) support legislation to end lynching and mob violence against individuals and groups in the United States.~~ RESOLVED, That our AMA reaffirm policy H- 65.952 “Racism as a Public Health Threat.”	No action; already in Digest
Resolution 11—Improvement in Care and Resource Allocation	IMPROVEMENT OF CARE AND RESOURCE ALLOCATION FOR HOMELESS PERSONS IN THE GLOBAL PANDEMIC	No action; already in Digest

for Homeless Persons in the Global Pandemic	RESOLVED, That our AMA support training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; and be it further RESOLVED, That our AMA support the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and be it further RESOLVED, that our AMA reaffirm existing policies H-160.903, "Eradicating Homelessness," and H-345.975, "Maintaining Mental Health Services by States"; and be it further RESOLVED, that our AMA reaffirm existing Policy H-160.978, "The Mentally Ill Homeless", with a title change "Housing Insecure Individuals with Mental Illness."	
Resolution 12—Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers	RESOLVED, That our AMA review ~~affirmatively monitor and solicit media and member~~ reports of unsafe working conditions and unfair retaliation for public expression of safety concerns on the part of physicians and trainees and consider methods ~~to investigate and intervene~~ to provide logistical and legal support to such aggrieved parties; and be it further RESOLVED, That our AMA develop and distribute specific guidelines on how physicians and trainees may make public comments on working conditions and legal options to promote workplace safety (e.g. filing formal OSHA complaints), as well as other workplace protection issues as appropriate; and be it further RESOLVED, That AMA policy H-440.810 be amended by addition to read as follows: 1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises. 2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions. 3. Our AMA will AMA advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need. 4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgment and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.	No action; already in Digest

	5. Our AMA supports a physician's right to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster; resident physicians and medical students must have the right to participate in public commentary addressing the adequacy of resources for their own safety in such conditions. 6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies. 7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.; and be it further ~~RESOLVED, That our AMA advocate for legislation requiring hospitals that employ or contract with physicians at all stages of training provide due process protections to such individuals; and be it further~~ RESOLVED, That our AMA support legislation and other policies protecting physicians and medical students from violence and unsafe working conditions; and be it further RESOLVED, That this resolution be immediately forwarded to our AMA House of Delegates at the November 2021 Special Meeting.	
	Annual 2022	
Emergency Resolution 1— Opposition and Stance on a Permanent Reference Committee	RESOLVED, that our AMA-RFS strongly opposes the use of a Resolution Committee or similar "representative" body to filter out resolutions from the business of the HOD without the opportunity for universal extraction, and be it further RESOLVED, if a Resolution Committee is to inevitably be established, that our AMA-RFS will advocate for the following composition and rules: 1. Members representing the RFS and MSS shall be appointed by their respective Governing Councils for a one-year term 2. The composition of the Resolution Committee will be representative of AMA membership. 3. Resolution Committee members will be term limited and cannot serve for more than four years in total. 4. The Resolution Committee shall meet at least once to discuss all resolutions prior to voting. Resolutions submitted later by those societies or sections that meet after the resolution deadline (i.e. resolutions normally included in the Tote) will be	No action; already in Digest.

	discussed by the Resolution Committee and voted on prior to the publication of the Resolution Committee report. 5. Members will rank each resolution by priority on a single 0-to-5-point scale. The median score will be used to rank resolutions. A threshold for inclusion can be recommended, but extraction from the report will be possible for all resolutions. 6. Extraction of a resolution from the Resolution Committee report shall only be prevented by a two-thirds vote of the House of Delegates. 7. The deliberations of the Resolution Committee will be free of input or influence from the AMA Board of Trustees, Presidents, Speakers, or Councilors. <u>If a resolution committee is not established by Annual 2023, this Resolved shall be removed from the AMA-RFS policy digest.</u>	
Late Resolution 1— Preserving Access to Reproductive Health Services	RESOLVED, that our AMA: (1) Recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) Opposes limitations on access to evidence- based reproductive health services, including fertility treatments, contraception, and abortion; (3) Will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) Supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) Opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) Opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) Will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or (8) Will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at I-22; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at A-22.	No action; already in Digest.
Resolution 1—	ILLICIT DRUG USE HARM REDUCTION STRATEGIES	No action; already

Legalization of Fentanyl Test Strips Resolution 4—In Support of Drug Checking Services	RESOLVED, That our AMA amend current policy D-95.987, "Prevention of Drug-Related Overdose," by addition to read as follows: 4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the possession, distribution, and use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies. 5. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.	in Digest.
Resolution 2—Assessing the Humanitarian Impact of Sanctions	RESOLVED, That our AMA recognizes that economic sanctions can negatively impact health and exacerbate humanitarian crises; and be it further RESOLVED, That our AMA supports ~~legislative and regulatory~~ efforts to study the ~~humanitarian~~ humanitarian ~~health~~ impact of economic sanctions imposed by the United States.	No action; already in Digest.
Resolution 3—Comprehensive Solutions for Medical School Graduates Who are Unmatched or Did Not Complete Training	COMPREHENSIVE SOLUTIONS FOR MEDICAL SCHOOL GRADUATES WHO ARE UNMATCHED OR DID NOT COMPLETE TRAINING RESOLVED, That our AMA work with US Centers for Medicare and Medicaid Services and other relevant stakeholders to create a commission to estimate future physician workforce needs and suggest re-allocation of available residency funding and available first-year positions accordingly; and be it further ~~RESOLVED, That our AMA-RFS study the possibility of a pathway to ACGME certification of training, ABMS board certification, and ultimately independent practice in primary care for unmatched graduates of US MD and DO schools who take roles as "Assistant Physicians" or similar positions as established by several states.~~ RESOLVED, That our AMA work with relevant stakeholders to study the possibility of alternative pathways to ACGME certification of training, ABMS board certification, and medical practice for unmatched medical school graduates.	No action; already in Digest.
Resolution 5—The Criminalization of Medical Errors	THE CRIMINALIZATION OF HEALTH CARE DECISION MAKING AND PRACTICE RESOLVED, That policy H-160.946, "The Criminalization of Health Care Decision Making" be amended by addition and deletion with a change in title to read as follows: The Criminalization of Health Care Decision Making and	No action; already in Digest.

	Practice H-160.946 That our ~~The~~ AMA: (1) opposes the attempted criminalization of health care decision-making, practice, malpractice, and medical errors, including medication errors related to electronic medical record or other system errors, ~~especially as represented by the current trend toward criminalization of malpractice~~; it interferes with appropriate decision making and is a disservice to the American public; ~~and~~ (2) actively update and promote ~~will develop~~ model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making and practice, including cases involving allegations of medical malpractice and medical errors~~,~~; and (3) implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making, practice, malpractice, and medical errors. RESOLVED, that our AMA study the increasing criminalization of health care decision-making, practice, malpractice, and medical errors with report back on our advocacy to oppose this trend. RESOLVED, That our AMA study the ramifications of trying all health care decision-making, practice, malpractice, and medical error cases in health courts instead of criminal courts. RESOLVED, That our AMA reaffirm policies H-120.921, H-160.954, H-375.984, H-375.997, and H-435.950; and be it further RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at A-22.	
Resolution 6—Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time	RESOLVED, That our AMA supports the elimination of seasonal time changes; and be it further RESOLVED, That our AMA supports the adoption of year-round standard time; and be it further RESOLVED, That this resolution be ~~immediately~~ forwarded to our House of Delegates at the 2022 AMA ~~Annual~~ Interim Meeting.	No action; already in Digest.
Resolution 7—Analysis of Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and Other Relevant Associations or Organizations	RESOLVED, That our AMA advocate for significant modification or the repeal of Section 207 of the Pension Funding Equity Act of 2004 such that evidence of anti-competitive actions against the NRMP be admissible in federal court; and be it further RESOLVED, That our AMA work with relevant stakeholders to study alternative strategies for resident matching that	No action; generated a report.

	ensure comparable efficiency and adequate market appreciation for medical residents.	
	Interim 2022	
Resolution 1—Prohibition of Death Penalty for Persons with Serious Mental Illness	RESOLVED, That our AMA-RFS support that defendants charged with capital crimes should not be sentenced to death or executed if, at the time of the offense, they had a mental disorder or disability that significantly impaired their capacity to appreciate the nature, consequences or wrongfulness of their conduct, to exercise rational judgment in relation to their conduct, or to conform their conduct to the requirements of the law.	No action; already in Digest.
Resolution 2—Increasing Female Representation in Oncology Clinical Trials	RESOLVED, That our AMA amend H-460.911, Increasing Minority Participation in Clinical Research, by addition and deletion to read as follows: Increasing Minority and Underrepresented Group Participation in Clinical Research H-460.911 1. Our AMA advocates that: a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations. b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and c. Resources be provided to community level agencies that work with those minorities and underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans. 2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities and underrepresented groups in clinical trials: a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs; b. Increased outreach to ~~female~~ all physicians to encourage recruitment of ~~minority and female~~ patients from underrepresented groups in clinical trials; c. Continued ~~minority physician~~ education for all physicians and physicians-in-training on clinical trials, subject	No action; already in Digest.

	recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients; d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and e. Fiscal support for minority and underrepresented group recruitment efforts and increasing trial accessibility through optimized patient-centered locations for accessing trials, the ready availability of transportation to and from trial locations, child care services, and ~~transportation, child care,~~ reimbursements, ~~and location.~~	
Resolution 4—Supporting the Use of Renewable Energy in Healthcare	RESOLVED, That our AMA-RFS advocate for ~~disseminate a public statement highlighting~~ the importance of healthcare systems' timely transition to renewable energy, including wind, solar, geothermal technology, biomass, and hydropower energy; and be it further RESOLVED, That our AMA-RFS support implementations of policies and incentives that promote the healthcare sector's transition to renewable energy.	No action; already in Digest.
Resolution 5—Medical School Management of Unmatched Medical Students	RESOLVED, That our AMA convene a task force of appropriate AMA councils, medical education organizations, licensing and credentialing boards, government bodies, impacted communities, and other relevant stakeholders to: 1. Study institutional and systemic factors associated with the unmatched medical graduate status, including, but not limited to: a) The GME bottleneck on training positions, including the balance of entry-level and categorical/advanced positions; b) New medical schools and the expansion of medical school class sizes; c) Race, geography, income, wealth, primary language, gender, religion, ability, and other structural factors; d) Student loan debt; e) Predatory business practices by medical schools, loan agencies, private equity, and other groups that prioritize profit over student success rates; f) The context, history, and impact of past reports on the state of undergraduate medical education, including the Flexner Report; g) The format and variations of institutional and medical organization guidance on best practices to successful matching; 2. Develop best practices for medical schools and medical organizations to support unmatched medical graduates, including, but not limited to: a) Tools to identify and remediate students at high risk for not	No action; already in Digest.

	matching into GME programs; b) Adequate data on student success rates (e.g., by specialty), and factors associated with success in matching; c) Medical school responsibilities to unmatched medical students and graduates; d) Outcomes-based tuition relief or reimbursement for unmatched students, wherein, unmatched students are returned some component of their tuition to ease the financial burden of being unable to practice clinical medicine; e) Transparent, equity-based solutions to address and ameliorate any inequities identified in the match process; f) Alternative, cost-neutral, graduate-level degrees with earlier graduation for students at high risk for not matching ~~(e.g., Master of Medical Sciences);~~ g) Career opportunities for unmatched U.S. seniors and US-~~IMGs, including, but not limited to, a streamlined portal for non-clinical positions, opportunities to transfer accrued educational credits to alternative advanced clinical degrees (e.g., NP or PA programs), and short-term clinical remediation programs with pathways to residency positions;~~ and 3. Require transparency from stakeholders, including medical schools, about any actions taken based on the report of this task force, particularly with regard to the remediation of medical students.	
Resolution 6— Support for GME Training in Reproductive Services	RESOLVED, That RFS internal position statement 294.017R, "~~Academic Freedom~~," be amended by addition and deletion to read as follows: Academic Freedom Access to Medication and Procedural Abortion Training That our AMA-RFS: (1) support the opportunity for residents to learn medication and procedural~~es for~~ abortion ~~termination of pregnancy~~; ~~and~~ (2) oppose efforts by other persons, governments, or organizations to interfere with or restrict the availability of training in medication and procedural~~es~~ for abortion ~~termination of pregnancy~~.; and (3) in the event that medication and procedural abortion are limited or otherwise unavailable at a home institution, supports cost subsidization for trainees traveling out-of-state and/or to another program to have hands-on training in medication and procedural abortion.; and be it further RESOLVED, That AMA policy H-295.923, "Medical Training and Termination of Pregnancy," be amended by addition and deletion to read as follows: Medical Training and Termination of Pregnancy 1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health	No action; already in Digest.

	importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy. 2. Our AMA ~~supports~~ will advocate for the availability of abortion education and hands-on exposure to medication and procedural abortion ~~procedures for termination of pregnancy, including medication abortions~~, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training. 3. In the event that medication and procedural abortion are limited or illegal in a home institution, our AMA supports pathways, including cost subsidization, to ensure trainees traveling to another program have hands-on training in medication and procedural abortion, and will advocate for legal protections for both trainees who cross state lines to receive education on reproductive health services, including medication and procedural abortion, as well as the institutions facilitating these opportunities. ~~3~~4. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the relevant Residency Review Committees ~~Review Committee for Obstetrics and Gynecology~~ and the American College of Obstetricians and Gynecologists' recommendations.; and be it further RESOLVED, That our AMA reaffirm policies H-100.948 "Supporting Access to Mifepristone (Mifeprex)" and H-425.969 "Support for Access to Preventive and Reproductive Health Services"; and be it further RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November 2022 Interim Meeting.	
Report A— Analysis of Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations	1. That the following resolved clauses be adopted in lieu of the original resolution: a) RESOLVED, That our AMA-RFS support efforts which seek to weaken the antitrust exemption for graduate medical education programs and the MATCH as stated in Section 207 of the Pension Funding Equity Act of 2004. ~~such that evidence of anti-competitive actions against the NRMP be admissible in federal court~~; and be it further b) RESOLVED, That our AMA study ~~with relevant stakeholders~~ alternatives to the current residency and fellowship MATCH process which would be less restrictive on free market competition for applicants. ~~to study alternative strategies for resident matching that ensure comparable efficiency and adequate market appreciation~~	No action; already in Digest.
	Annual 2023	

Late Resolution 1—Stand Your Ground Laws	RESOLVED, That our AMA's Gun Violence Task Force address and consider study the public health implications of "Stand Your Ground" laws and castle doctrine; and be it further RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	No action; already in Digest.
Resolution 1—Confidentiality of Sexual Orientation and Gender Identity Data	RESOLVED, That AMA policy H-65.959, "Opposing Mandated Reporting of People Who Question Their Gender Identity" be amended by addition and deletion to read as follows: Our AMA opposes mandated reporting or disclosure of patient information related to sexual orientation, of individuals who question or express interest in exploring their gender identity, gender dysphoria, intersex identity, and any information related to gender transition for all individuals, including minors. RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	No action; already in compendium
Resolution 3—Amend Policy D-275.948, "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training"	RESOLVED, That our AMA amend policy D275.948 by addition to read as follows: 1.) Our AMA acknowledges that a conflict of interest exists when non-physician health care professionals hold positions on physician regulatory bodies or physician boards when these individuals represent a field that either possesses or seeks to possess the ability to practice without physician supervision; and 2). Our AMA will work with and advocate to key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (1) increase transparency of the process by encouraging them to openly disclose how their board is composed and Imm. Fwd to HOD @ A-23; became Res. 323; Adopted as amended. (see below) This document does not represent official policy of the American Medical Association (AMA). Refer to AMA PolicyFinder for official policy of the Association. 4 members are selected; and (2) review and amend their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that nonphysician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision; and 3.) Our AMA opposes any non-physician having a voting position on a regulatory body or physician board responsible for physician education, accreditation, certification, licensing, or credentialing; and be it further RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	No action; already in Digest.
Resolution 5—Elimination of NonCompete Clauses in Employment Contracts Resolution 10— Support of Banning Non-Compete Contracts for Physicians	ELIMINATION OF NON-COMPETE CLAUSES IN EMPLOYMENT CONTRACTS RESOLVED, That our AMA support the elimination of restrictive not-to-compete clauses within contracts for all physicians in clinical practice, regardless of the for-profit or non-forprofit status of the employer; and be it further RESOLVED, That our AMA strongly advocate for policies that enable all physicians, including residents and fellows currently in training, to have greater professional mobility and the ability to serve multiple hospitals, thereby increasing specialist coverage in	No action; already in Digest.

	communities and improving overall patient care; and be it further RESOLVED, That our AMA ask the Council on Ethical and Judicial Affairs to evaluate amending the AMA Code of Medical Ethics in order to oppose non-compete clauses; and be it further RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	
Resolution 6— Redressing the Harms of Misusing Race in Medicine	RESOLVED, That our AMA recognize the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field; and be it further RESOLVED, That our AMA revise the AMA Guides to the Evaluation of Permanent Impairment, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or racebased medicine; and be it further RESOLVED, That our AMA support and promote racism-conscious, reparative, community-engaged interventions at the health system, organized medical society, payor, local, state, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine.; and be it further RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	No action; already in Digest.
Resolution 7— Decriminalizing and Destigmatizing Perinatal Substance Use Treatment	RESOLVED, That our AMA will advocate that prenatal and peripartum toxicology tests should not be obtained without the informed consent of the birthing parent, if they have capacity to provide consent; and be it further RESOLVED, That our AMA-RFS support will advocate that state and federal child protection laws should be amended so that reporting of pregnant people with substance use disorders are only reported to welfare agencies when protective concerns are identified by the clinical team, rather than through mandated or categorical referral of all pregnant people with a positive toxicology test or verbal substance use screen. RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the 2023 Annual Meeting.	No action; already in Digest.
Resolution 8— Adopting a Neutral Stance on Medical Aid and Dying	RESOLVED, That our AMA adopt study the impact of adopt a neutral stance on medical aid in dying and respect respect the autonomy and right of self-determination of patients and physicians in this matter; and be it further RESOLVED, That our AMA-RFS support the research to better understand the study the benefits and risks of medical aid in dying, and to how such aid might affect improve the quality of end-of-life care.	No action; already in Digest.
Resolution 9— Trafficrelated Death as a Public Health Crisis	RESOLVED, That our AMA recognize traffic related death as a preventable public health crisis that disproportionately harms marginalized populations; and be it further RESOLVED, That Our AMA recognize walking and cycling as healthy behaviors and walking and cycling safety as fundamental rights, especially for marginalized populations; and be it further RESOLVED, That Our AMA support evidencebased strategies to achieve zero traffic fatalities by 2050; and be it further RESOLVED, That Our AMA recognize	No action; generated a report.

	that vehicle speed and weight are modifiable risk factors for traffic-related deaths.	
Resolution 11— Editorial Changes to Outdated and Stigmatizing Language in the RFS Digest of Actions	RESOLVED, That our AMA-RFS review our RFS position statements to editorially update outdated and stigmatizing language as guided by “Advancing Health Equity: A guide to language, narrative, and concepts” on a regular basis, with the language reflected in the Sunset Report; and be it further RESOLVED, That our AMA-RFS will use clinically accurate, non-stigmatizing terminology in all future resolutions, reports, and educational materials and discourage the use of stigmatizing terms	No action; generated a report.
Resolution 12— Inclusion of All Passed Resolutions in the RFS Digest of Actions	RESOLVED, That our AMA-RFS retain all resolutions passed in RFS assembly in our RFS Digest of Actions, including those that pass at the AMA House of Delegates; and be it further RESOLVED, That our AMA-RFS review study past versions of our RFS Digest of Actions with a lookback period of up to 10 years to restore RFS policy that passed at the AMA House of Delegates and was subsequently removed.	No action; generated a report.
Resolution 13— Updating Language Regarding Families and Pregnant Persons	RESOLVED, That our AMA-RFS review and update the language used in our RFS Digest of Actions, and other resources and communications, to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures; and be it further RESOLVED, That our AMA review and update the language used in AMA policy, and other resources and communications, to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures.	No action; generated a report.
Report B— On the Creation of an RFS JEDI Committee	Based on the report and recommendations prepared by the AMA-RFS JEDI Ad-Hoc Committee, your AMA-RFS Governing Council recommends that the following be adopted and the remainder of the report be filed: 1. That our AMA-RFS formally found a Justice, Equity, Diversity, and Inclusion (JEDI) Standing Committee. 2. That the description of the AMA-RFS JEDI Standing Committee be as follows: Justice, Equity, Diversity, and Inclusion (JEDI) Standing Committee: This committee is dedicated to strengthening our Resident-Fellow Section through the promotion of justice, equity, diversity, and inclusion. Committee efforts are aligned with the strategic plan of the AMA Center for Health Equity. The committee aims to build justice and equity into our policy, advocacy, and business, and to ensure that the full diversity of resident and fellow membership is represented, welcome, and supported as members and in leadership. Committee members also work with the Governing Council and other stakeholders to create educational programing and policy. 3. That the responsibilities of the AMA-RFS JEDI Standing	No action; already in Digest.

	Committee be as follows: (a) Review of RFS resolutions and programming/webinar proposals for their impact on JEDI-related topics and collaboration to strengthen RFS policy for JEDI-related causes; (b) Regular creation and curation of JEDI-related content and programming for the RFS; (c) Act as liaisons with other JEDI-related groups within the AMA; (d) As-needed advocacy within our RFS and the AMA for greater support and implementation of JEDI within our organization and within healthcare	

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: F
(A-24)

Introduced by: RFS Governing Council

Prepared by: RFS Justice Equity Diversity and Inclusion (JEDI) Committee

Subject: Editorial Changes to Outdated and Stigmatizing Language in the RFS Digest of Actions

Referred to: Reference Committee

Introduction

At its 2023 Annual Meeting, the AMA-RFS Assembly considered the resolution "Editorial Changes to Outdated and Stigmatizing Language in the RFS Digest of Actions," which stated the following:

> RESOLVED, That our AMA-RFS review our RFS position statements to editorially update outdated and stigmatizing language as guided by "Advancing Health Equity: A guide to language, narrative, and concepts" on a regular basis, with the language reflected in the Sunset Report; and be it further
>
> RESOLVED, That our AMA-RFS will use clinically accurate, non-stigmatizing terminology in all future resolutions, reports, and educational materials and discourage the use of stigmatizing terms.

The A-23 Reference Committee heard unanimous testimony in support of Resolution 11 and recommended that Resolution 11 be adopted as written. It was subsequently assigned to the RFS Committee on Justice, Equity, Diversity and Inclusion to implement.

Background

The AMA's general policy on language is straightforward. As H-140.831 states, "Our AMA encourages the use of person-centric language." That means as a physician, one would discuss a "50-year-old male with diabetes that presents for follow-up," and not "A 50-year-old diabetic male that presents for follow-up." There are examples of policy regarding specific terminology substitutes, but not a plethora. These include "unhealthy weight" over "obese" in H-440.821, and "substance use disorder" over "substance abuse," "positive UDS" over "dirty UDS" in H-95.917, etc.

In November 2021, the AMA published *Advancing Health Equity: A Guide to Language, Narrative and Concepts*.[1] The underlying framework is that messages (words and images) can affect how stories and experiences are framed and conveyed. On a larger scale, narratives about topics will grow from sharing their experience. On an individual level, the "Deep Narrative" of self-values may parallel the language used. Part 1 of the guide offers equity-centered alternatives for outdated terms. Importantly, it acknowledges that the context of language matters. An appropriate patient-centric presentation delivered with a negative tone should be viewed differently than a patient-presentation using outdated terms that is given by a concerned physician with the patient's health and best interests in mind. Furthermore, specific terminology suggestions may not be agreed upon by all individuals of different backgrounds.

Advancing Health Equity is not a "definitive list of 'correct' terms, but rather … guidance on equity-focused, person-first language."

To that end, the RFS-JEDI committee has strived to review the *RFS Digest of Actions* keeping in-mind person-first language, while proposing reasonable terminology changes that influence the narratives regarding RFS policy and patients, but do not change the meaning of the policy. This was done considering that language evolves over time, and that meaning of terms is not static.

Discussion

In the RFS policy compendium, there were a number of different policies that could be modified to focus on equity-focused and person-first language. In Supplement 1, there is a breakdown of each policy in the RFS policy compendium and whether there are recommended improvements based on the recommendations made in *Advancing Health Equity.*

Another resolution from A-23, "Updating Language Regarding Families and Pregnant Persons," which was also referred to the RFS-JEDI committee, had similar asks. Due to concerns about two reports making different recommendations at the same meeting for the same policies, all resolutions that had language that could be updated to meet the recommendations in *Advancing Health Equity* were deferred to the report requested by the separate resolution, "Updating Language Regarding Families and Pregnant Persons."

On recommendations, your RFS-JEDI committee erred on the side of making changes in line with the recommendations in *Advancing Health Equity,* provided the changes did not meaningfully change the asks of the resolution to best meet the guidelines laid out by the asks of the resolution, "Editorial Changes to Outdated and Stigmatizing Language in the RFS Digest of Actions."

JEDI Report- Policy Breakdown (Supplement 1)
https://docs.google.com/spreadsheets/d/1pNdxM9jiASbw4mpwqEgAVjl0iGTukbLgmATaL_Y_tSA/edit?usp=sharing

Conclusion

Your RFS-JEDI committee would like to thank the authors and the RFS for calling for improvements to the RFS policy compendium to bring RFS policy in line with the standards set forth by the leaders in the AMA and other leaders in medicine who developed the *Advancing Health Equity* guide.

Recommendation

Based on the report and recommendations prepared by the AMA-RFS Committee on Justice, Equity, Diversity and Inclusion (JEDI), your RFS Governing Council recommends:

1. That the following additions and deletions are made to the following existing internal AMA-RFS policies:

    a) RESOLVED, policy 20.003 be amended by addition and deletion as follows: Review of AMA Policy on Physicians with HIV ~~HIV-Infected Physicians~~: That our AMA-RFS strongly support proposed changes in the Council on Ethical and Judicial Affairs (CEJA) Opinion 4-A-99, Physicians and Infectious Diseases and CEJA and Opinion 5-A-99, HIV-Infected Patients and Physicians, which change the terminology regarding the level of risk of physician-to-patient transmission of

bloodborne infections appropriate for restricting a physician's medical practice from "identified risk" to "significant risk." And be it further

b) RESOLVED, policy 30.001 be amended by addition and deletion as follows: Alcohol and Youth: That our AMA-RFS support: (1) state medical societies working with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol and (2) working with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry focused ~~aimed at~~ on adolescents; and be it further

c) RESOLVED, policy 120.001 be amended by addition and deletion as follows: U.S. Farm Subsidies: That our AMA-RFS support reform and updates to the US Farm Bill including redirecting subsidies in the US Farm Bill that perpetuate calorie-dense, nutrition-poor products toward programs that reduce ~~aimed at combating~~ obesity; and be it further

d) RESOLVED, policy 130.002 be amended by addition and deletion as follows: Marriage Equality to Reduce Health Care Disparities: That our AMA-RFS support ending the exclusion of same-sex couples from civil marriage in order to reduce health care inequities ~~disparities~~ affecting those gay and lesbian individuals and couples, their families and their children; and be it further

e) RESOLVED, policy 130.006 be amended by addition and deletion as follows: Cost-Effectiveness of Medicaid Eligibility Criteria for People with Chronic Illness ~~the Chronically Ill~~: That our AMA examine the appropriateness and cost-effectiveness of "the spend down option" to meet Medicaid eligibility criteria in the broader context of Medicaid reform with a report back at I-02; and be it further

f) RESOLVED, policy 130.016 be amended by addition and deletion as follows: Developing Sustainable Solutions to Discharge of People who are Experiencing Homeless ~~Chronically Homeless Patients~~: That our AMA-RFS support working with relevant stakeholders in developing sustainable plans for the appropriate discharge of people who are experiencing homeless ~~chronically homeless patients~~ from hospitals; and be it further

g) RESOLVED, policy 170.009 be amended by addition and deletion as follows: Addressing the Physician Workforce Shortage by Increasing GME Funding: 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 disinvested ~~under-served~~ areas that foster resident training programs, offer loan repayment, and support independent practice development as a means to address the physician workforce shortage; and be it further

h) RESOLVED, policy 260.003 be amended by addition and deletion as follows: NRMP All-In Policy: That our AMA-RFS does not support the current “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process. Also asked that the AMA work with the NRMP, and other external bodies (1) to revise match policy, including the secondary match or scramble process to create more standardized rules for all candidates and (2) to develop mechanisms that limit inequities ~~disparities~~ within the residency application process and allow both flexibility and standard rules for applicants; and be it further

i) RESOLVED, policy 260.008 be amended by addition and deletion as follows: Eliminating Health Inequities ~~Disparities~~ - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education: That our AMA-RFS support: (1) the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age, (2) students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) the Liaison Committee on Medical Education (LCME) and the Accreditation Council of Graduate Medical Education (ACGME) including LGBT health issues in the structural competence ~~cultural competency~~ curriculum for medical education; and be it further

j) RESOLVED, policy 260.015 be amended by addition and deletion as follows: Establishing Essential Requirements for Medical Education in Substance Abuse: That our AMA-RFS support: (1) that alcohol and other drug abuse education needs to be an integral part of medical education; and (2) the development of programs to train medical students in the identification, treatment and prevention of alcohol use disorder ~~alcoholism~~ and other chemical dependencies; and be it further

k) RESOLVED, policy 260.018 be amended by addition and deletion as follows: Evaluation of Changes to Residency and Fellowship Application and Matching Processes: That our AMA-RFS: (1) support proposed changes to residency and fellowship application requirements only when: (a) those changes have been evaluated by working groups which have students and residents as representatives, (b) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (c) There are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from historically marginalized ~~minority~~ backgrounds, and (d) the costs to medical students and residents are mitigated; (2) oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such

time as the above conditions are met; and (3) support working 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; and be it further

l) RESOLVED, policy 292.001 be amended by addition and deletion as follows: Amending the ACGME Residency Due Process Requirements: That our AMA-RFS support the amendment of the ACGME's Institutional Requirements to specifically require that institutional grievance policies governing the dismissal or non-renewal of a resident or fellow include the following principles, in writing:

1. Notification must be issued to a resident when disciplinary action is to be taken, the reasons for the adverse action, a detailed outline of the due process procedure, including the resident's rights, if applicable, to a hearing and any time limitation for an appeal to the action;
2. If the action involves the non-promotion, contract non-renewal, or dismissal of a resident, the appellate process must include the right to a fair, objective, and independent hearing before a multi-person review committee, during which the resident should be entitled to present a defense to the charges against them ~~him or her~~;
3. Review committees should be comprised of physicians and include a consequential number of persons at a similar level of training as the aggrieved resident to judge whether the actions of the resident were reasonable based on the perception of a fellow trainee similarly situated;
4. Review committees should not include any person directly involved in the circumstances surrounding the incident(s) giving rise to the action against the resident;
5. All material information obtained by the review committee regarding the subject of the review hearing should be made available to the resident, or their ~~his or her~~ attorney, in a timely manner prior to the hearing;
6. Program directors and residents should have the right to be represented by an attorney during review hearings. Program directors, residents, or their respective attorneys should be permitted to call and examine/cross-examine witnesses and present evidence during the review hearing;
7. Program directors, residents, or their respective attorneys should receive a written statement of the review committee's recommendation and the basis for the decision;
8. Residency program disciplinary policies should state whether a resident will continue to receive their compensation pending a final decision on any disciplinary action;
9. Residency program disciplinary policies should include a reasonable process by which residents can obtain their training record for any reason; and be it further

m) RESOLVED, policy 292.010 be amended by addition and deletion as follows: Due Process System for Residency Programs: That the AMA-RFS maintain the following principles for due process system for residency programs:

(1) A personal record of evaluation should be maintained for each resident which is accessible to the resident.
(2) A resident should have the opportunity to challenge the accuracy of the information in his/her resident record.
(3) At least annually, but preferably semi-annually, the program director and teaching staff should evaluate each resident's performance and provide each resident with this evaluation.
(4) Each resident should expect to continue to the next level of training, unless they are ~~he/she is~~ given adequate notice and informed of reasons they ~~he/she~~ may not so advance.
(5) Residents should be involved in the development of recommendations on policy issues, involving education and patient care including the mechanism for evaluation or resident performance.
(6) There should be policies and procedures that define the bodies responsible for evaluation of residents and the function and membership of such bodies.

These policies and procedures should provide for timely and progressive verbal and written notification to the physician that his/her performance is in question, and provide an opportunity for the resident to learn why it has been questioned.

(7) There should be participation by residents in all institutional bodies involved in the evaluation of residents. Consideration should also be given to including staff physicians closely involved in housestaff interactions. Those residents participating should have full voting rights. Representatives of the housestaff should be selected by members of the housestaff.

(8) These policies and procedures should also provide that when a resident has been notified of an adverse action, they have ~~he/she has~~ adequate notice and opportunity to appear before a decision-making body to respond to the charges and introduce his/her own rebuttal. Dismissal from the program, the replacing of the resident on probation or otherwise depriving the resident of the property rights to which he/she is entitled in order to continue in the program constitutes an adverse action.

(9) The fundamental aspects of a fair hearing are: a listing of specific changes, adequate notice of the right to a hearing, the opportunity to present and to rebut the evidence, and the opportunity to present a defense.

(10) A hearing should be conducted and a decision reported to the resident in a timely manner thereby minimizing interruption of the resident's training.

(11) The resident should be permitted to be accompanied by another physician or advisor at the hearing of their ~~his/her~~ choice.

(12) A record of the hearing should be made and retained for review by interested parties who have obtained the written consent of the resident.

(13) The policies and procedures should include an appeal mechanism within the institution.

(14) All matter upon which the decision is based must be introduced into evidence at the proceeding before the hearing committee in the presence of the resident. An appeal of the decision of the hearing is limited to matters introduced at the hearing and made available to the resident.

(15) Pending a final decision of the adverse action by the appellate body for the program, the resident should be permitted to continue in the training program except in the extraordinary case where patient safety and well being would be in jeopardy in the hospital; and be it further

n) RESOLVED, policy 294.003 be amended by addition and deletion as follows: Improving Access to Care and Health Outcomes: That our AMA-RFS support training opportunities for students and residents to learn cultural humility ~~cultural competency~~ for community health workers; and be it further

o) RESOLVED, policy 295.010 be amended by addition and deletion as follows: That our AMA-RFS support the Accreditation Council for Graduate Medical Education (ACGME): (1) establishing guidelines for non-academic closure or downsizing of residency programs and adequate advance notification to residents wherein such guidelines could include providing residents with information, resource contacts, assistance to facilitate transfer to another accredited training program where they could complete their training, and financial assistance programs; and (2) considering waiving requirements for continuous years of training at one program and other restrictions that would otherwise significantly delay their normal tenure for completion of training in the event a resident has been subject to the closure or downsizing of their ~~his or her~~ residency program; and be it further

p) RESOLVED, policy 340.006 be amended by addition and deletion as follows: Encouraging Protocols to Assist with the Management of Obese Patients: That our AMA-RFS support healthcare providers learning about techniques and devices to prevent potential injury and to provide safe and efficient care for patients who are obese ~~obese patients~~; and be it further

q) RESOLVED, policy 340.009 be amended by addition and deletion as follows: Delegation of Informed Consent: That our AMA-RFS support: (1) that a qualified physician be able to delegate their ~~his or her~~ duty to obtain informed consent to another provider that has knowledge of the patient, the patient's condition, and the procedures to be performed on the patient; and (2) studying the implications of the Shinal v. Toms ruling and its potential effects on the informed consent process; and be it further

r) RESOLVED, policy 350.001 be amended by addition and deletion as follows: Opposition to Funding Cuts for HRSA Programs: That our AMA-RFS: (1) support working with other interested organizations to educate the public about the importance of the Health Careers Opportunity Program and the Centers of Excellence Program, which encourages ~~underrepresented~~ historically minoritized populations ~~minorities~~ to consider a career in medicine and helps to increase the supply of historically minoritized ~~minority~~ health professionals; and (2) oppose any proposed legislation to reduce or eliminate funding for the Health Careers Opportunity Program and the Centers of Excellence Program; and be it further

s) RESOLVED, policy 350.002 be amended by addition and deletion as follows: Increasing Diversity in the Medical Profession: That our AMA-RFS: (1) encourage its members to participate in mentoring and role-modeling programs such as the AMA MAC's Doctors Back to School Program in order to attract more minoritized and historically marginalized ~~minority~~ students towards the medical profession; and (2) support efforts to eliminate racial and ethnic health care inequities ~~disparities~~; and be it further

t) RESOLVED, policy 350.004 be amended by addition and deletion as follows: Recognition of National Anti-Lynching Legislation as Public Health Initiative: That our AMA-RFS support the AMA in supporting national legislation that recognizes lynching and mob violence towards an individual or group of individuals as hate crimes; working with relevant stakeholders to support medical students, trainees, and physicians receiving education on the inter-generational health outcomes related to lynching and its impact on the health of oppressed ~~vulnerable~~ populations; and amending AMA Policy H-65.965 "Support of Human Rights and Freedom" to read: (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, phenotypic appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States; and reaffirming AMA policy H-65.952 "Racism as a Public Health Threat; and be it further

u) RESOLVED, policy 350.005 be amended by addition and deletion as follows: Improvement of Care and Resource Allocation for People who are Experiencing Homelessness ~~Homeless Persons~~ in the Global Pandemic: That our AMA-RFS support the AMA in supporting training to understand the needs of housing insecure individuals for those who encounter this disenfranchised ~~vulnerable~~ population through their professional duties; and supporting the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and reaffirming existing policies H-160.903, "Eradicating Homelessness," and H-345.975, "Maintaining Mental Health Services by States," and H-160.978, "The Mentally Ill Homeless", with a title change to "Housing Insecure Individuals with Mental Illness;" and be it further

v) RESOLVED, policy 350.007 be amended by addition and deletion as follows: Increasing Minoritized and Historically Marginalized ~~Minority and Underrepresented~~ Group Participation in Clinical Research:

That our AMA-RFS support our AMA in amending H-460.911, Increasing Minority Participation in Clinical Research, by addition and deletion to read as follows: Increasing Minoritized and Historically Marginalized ~~Minority and Underrepresented~~ Group Participation in Clinical Research H-460.911

a. Our AMA advocates that: The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and historically minoritized populations are ~~minorities is~~ maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.

b. The FDA have a page on its web site that details the prevalence of historically minoritized populations ~~minorities~~ and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and

c. Resources be provided to community level agencies that work with historically minoritized populations ~~those minorities~~ and underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These historically minoritized populations ~~minorities~~ include African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and American Indian/Alaska Natives~~Native Americans~~.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of historically minoritized populations ~~minorities~~ and underrepresented groups in clinical trials:

a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;

b. Increased outreach to all physicians to encourage recruitment of patients from underrepresented groups in clinical trials;

c. Continued education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients;

d. Support for the involvement of historically minoritized ~~minority~~ physicians in the development of partnerships between minority communities and research institutions; and

e. Fiscal support for minority and underrepresented group recruitment efforts and increasing trial accessibility through optimized patient-centered locations for accessing trials, the ready availability of transportation to and from trial locations, child care services, and reimbursements; and be it further

w) RESOLVED, policy 380.013 be amended by addition and deletion as follows: Physician Diversity: That our AMA-RFS support AMA policies 350.988, 350.991, 350.993, and 350.995 which encourage increased representation by historically minoritized populations ~~minorities~~ in medicine; and be it further

x) RESOLVED, policy 410.028 be amended by addition and deletion as follows: Addressing Immigrant Health Inequities ~~Disparities~~: That our AMA-RFS support:

(1) urging federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children regardless of legal status, based on medical evidence and disease epidemiology;

(2) advocating against and publicly correcting medically inaccurate accusations that contribute to anxiety, fear, and marginalization of specific populations; and

(3) advocating for policies to make available and effectively deploy resources needed to narrow health disparities borne by immigrants, refugees, or asylees; and be it further

y) RESOLVED, policy 410.032 be amended by addition and deletion as follows: Coordinating

Correctional and Community Healthcare: That our AMA-RFS support: (1) linkage of people who are currently ~~those~~ incarcerated to community clinics upon release in order to accelerate access to primary care and improve health outcomes among this disenfranchised ~~vulnerable~~ patient population as well as adequate funding; and (2) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; and be it further

z) RESOLVED, policy 480.001 be amended by addition and deletion as follows: Opposition to Violent and Sexually Explicit Television Programming: That our AMA-RFS support: (1) the AMA's continuing efforts to work with state and federal agencies as well as private organizations to mitigate~~retard~~ the development of violent and sexually explicit programming; and (2) the AMA's continuing efforts to educate the public about the epidemiological risks of violent and sexually explicit television programming; and be it further

aa) RESOLVED, policy 490.001 be amended by addition and deletion as follows: Investigating the Continued Gender Inequities ~~Disparities~~ in Physician Salaries: That our AMA-RFS: (1) support eliminating gender inequities ~~disparities~~ in physician salaries and professional development (e.g. promotions, tenure); and
(2) oppose the causes of inequities ~~disparities~~ in physician salaries and professional development; and be it further

bb) RESOLVED, policy 550.002 be amended by addition and deletion as follows: Expanding Underrepresented ~~Minority~~ Voices of Racial and Ethnic Minority Groups in the AMA-RFS: That the AMA- RFS: 1) create bylaws to specifically and systematically outline how ~~a minority~~ physician organizations of racial and ethnic minority groups may gain representation in the RFS national assembly; 2) research the major underrepresented ~~minority~~ physician organizations of racial and ethnic minority groups with a focus on the level of involvement of resident and fellow members in each organization, on the percentage of AMA members in each organization, and on the level to which each minority physician organization desires to be involved with the AMA-RFS; 3) leadership work with the Specialty and Service Society (SSS) to determine the needed steps that ~~minority~~ physician organizations of racial and ethnic minority groups would have to take to become seated members of the AMA-HOD; and be it further

cc) RESOLVED, policy 590.005 be amended by addition and deletion as follows: Expanding AMA Participation by Underrepresented in Medicine ~~Minority Scholar~~ Award Winners: That our AMA- RFS increase recruitment and retention of future

award winners (including minority scholar award winners) by developing a strategic plan for leadership development and that our AMA-RFS report back on this issue at A-09.

REFERENCES:

1. American Medical Association and Association of American Medical Colleges. (2021) Advancing Health Equity: Guide on Language, Narrative and Concepts. Available at ama-assn.org/equity-guide.

RELEVANT AMA POLICY:

Destigmatizing the Language of Addiction H-95.917
Our AMA will use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports, and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty. [Res. 502, A-19]

Destigmatizing the Language of Addiction D-95.966
Our AMA and relevant stakeholders will create educational materials on the importance of appropriate use of clinically accurate, non-stigmatizing terminology and encourage use among all physicians and U.S. healthcare facilities. [Res. 502, A-19]

Person-First Language for Obesity H-440.821
Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully. [Res. 402, A-17, Modified: Speakers Rep., I-17]

Use of Person-Centered Language H-140.831
Our AMA encourages the use of person-centered language. [Res. 006, A-19]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: G
(A-24)

Introduced by: RFS Governing Council

Prepared by: RFS Justice Equity Diversity and Inclusion (JEDI) Committee

Subject: Updating Language Regarding Families and Pregnant Persons

Referred to: Reference Committee

Introduction

At its 2023 Annual Meeting, the AMA-RFS Assembly considered resolution 13, entitled “Updating Language Regarding Families and Pregnant Persons,” which stated the following:

> RESOLVED, that our AMA-RFS review and update the language used in our RFS Digest of Actions, and other resources and communications, to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures; and be it further
>
> RESOLVED, that our AMA review and update the language used in AMA policy, and other resources and communications, to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures.

This resolution received broad support. The AMA-RFS Assembly voted to adopt this resolution including its call for additional study and this report to evaluate the need for changes within RFS digest. This was accordingly prepared by your RFS Committee on Justice, Equity, Diversity and Inclusion to present related evidence and recommendations as seen below.

Background

The importance of inclusive language in healthcare is crucial to ensuring that all patients feel respected and acknowledged. Traditional medical language has often included gender-specific terms such as "pregnant women," which may not reflect the diversity of all individuals who may require obstetric and gynecologic care.

While many healthcare systems have worked to update the language surrounding their electronic medical records, we have forgotten the policy that governs our medical societies may also need to be updated.

Recognizing this, leading medical organizations, including the American College of Obstetricians and Gynecologists (ACOG), have initiated shifts toward more inclusive language, opting for terms like “pregnant persons” to accommodate the broad spectrum of gender identities.

This movement toward inclusivity is part of a broader societal shift that emphasizes the need to affirm diverse gender identities and family structures. The use of inclusive language is vital as it allows individuals to identify as they choose, which not only affirms their identity but also mitigates feelings of discrimination and alienation, thereby contributing positively to their mental and physical health outcomes. Notably, organizations like the Human Rights Campaign and the World Professional Association for Transgender Health (WPATH) have promoted policies that uphold principles of safety, dignity, and respect in patient interactions.

The current language used in the AMA-RFS Policy Digest and other AMA communications largely reflects outdated norms that use traditional, gendered terms. These terms have increasingly become misaligned with contemporary standards of care that prioritize inclusivity and respect for all gender identities. The resolution to update the language aims to align AMA's documents with the evolving societal norms and medical ethics, ensuring that all communications are reflective of and sensitive to the diversity seen in today's patient populations. This update is critical in creating a healthcare environment that recognizes and supports the varied identities of those it serves.

Discussion

In an era of evolving societal norms and recognition of diverse identities, it is imperative for the language utilized by the American Medical Association (AMA) to adapt accordingly. Specifically, in the realm of obstetric and gynecologic (OB/GYN) care, the language often used may inadvertently exclude or marginalize individuals and families who do not conform to traditional gender norms or family structures. As such, the two resolves outlined above advocate for the RFS and AMA as a whole to review and update its language to ensure inclusivity for all genders and family configurations.

The first resolved clause of the RFS resolution 13-A-23 called for the AMA-RFS to review and accordingly update the language utilized in the RFS Digest of Action, resources, and communications. Similarly, the second resolved clause called for the AMA to review and update language in AMA policy, resources, and communications. As outlined in the relevant AMA policy section, multiple policies have referenced terminology such as "pregnant women," "mothers," and "women" numerous times. This type of exclusionary language does not address the broad spectrum of individuals with sexual and reproductive health requirements and encounters, which may parallel or diverge from those of cisgender individuals.[4] Given multiple institutions including the National Institute of Health (NIH), the American Board of Obstetrics and Gynecology (ABOG), and ACOG as above have recognized the need for inclusive language, the AMA as leading medical advocacy organization should emulate as such.[2,5-6]

While reviewing prior verbiage to alter language could be an arduous process, it is a vital and integral task for the following reasons. Foremost, the medical community has a commitment towards honoring the diversity of its patient population. Furthermore, our policy and language should reflect the reality of the patient population – we as medical professionals effectively communicate with and provide care for all individuals regardless of their identity or familial situation. By transforming our language, we are encouraging medical professionals to do the same in their practices to allow for more trusting relationships with their patients.[4] Lastly, exclusionary language can contribute to disparities in healthcare access and outcomes, particularly for marginalized communities.[4,7-8] By adopting inclusive language, the RFS and AMA at large can help mitigate these disparities and promote equitable healthcare for all.

Conclusion

Upon review of the literature there is clear consensus that updated language is needed in regards to family structure and pregnant persons. In order to be in line with organizations that are clinical medicine leaders such as NIH, ABOG, and ACOG, this committee finds the AMA-RFS and AMA at large would benefit from including more inclusive language around families and pregnant persons. Reviewing the current RFS Digest, there is not consistent and/or cohesive language that promotes various family structures and pregnant persons. Observation of the AMA policy digest at large as well can benefit from cohesive language.

Your RFS-JEDI committee would like to thank the authors and the RFS for calling for improvements to the RFS policy compendium to bring RFS policy in line with the standards set forth by the leaders in the AMA and other leaders in medicine who developed the *Advancing Health Equity* guide.

Recommendation

Based on the report and recommendations prepared by the AMA-RFS Committee on Justice, Equity, Diversity and Inclusion (JEDI), your RFS Governing Council recommends the following:

1. That the following additions and deletions be made to the following internal AMA-RFS policies:

a) RESOLVED, policy 20.005 be amended by addition and deletion as follows: Review of AMA-RFS Policy on Prevention of Prenatal Transmission of HIVU: That our AMA-RFS support federal legislation requiring HIV testing of all ~~pregnant~~ ~~women~~ pregnant persons at the earliest prenatal visit, except when there is a specific signed refusal, in order to allow pregnant persons ~~women~~ the opportunity to improve their own health and that of their child." And be it further;

b) RESOLVED, policy 130.011 be amended by addition and deletion as follows: Review of AMA-RFS Policy on Hospital Stay for Healthy Term NewbornsU: That our AMA-RFS: (1) support the American Academy of Pediatrics and American College of Obstetricians and Gynecologists' guidelines concerning post-delivery care for ~~mothers~~ postpartum persons and their newborn infants and encourage state and federal legislation supporting these policies; and (2) support legislation mandating reimbursement for appropriate post-delivery care." And be it further;

c) RESOLVED, policy 291.004 be amended by addition and deletion as follows: Protecting Rights of Breast/Chestfeeding Residents and FellowsU: That our AMA-RFS support: (1) working with key stakeholders, including the ACGME, to mandate language in housestaff manuals or similar policy references of all training programs on the protected time and locations for milk expression and storage of breast milk; and (2) working with key stakeholders, including the ACGME and AAMC, to include language related to the learning and work environments for ~~breastfeeding mothers~~ breast/chestfeeding persons in regular program reviews." And be it further;

d) RESOLVED, policy 360.002 be amended by addition and deletion as follows: National Marrow Donor Program: Cord Blood DonationU: That our AMA-RFS support: (1) working with Health Resources and Service Administration to increase the availability and access for expectant ~~mothers~~ persons to donate their cord blood to the National Marrow Donor Program within every state; and
(2) drafting and promoting model state and federal legislation to present the option to all expectant ~~mothers~~ persons of donating cord blood." And be it further;

e) RESOLVED, policy 390.005 be amended by addition and deletion as follows: That our AMA-RFS support the following statements: (1) Judicial intervention is inappropriate when a ~~woman~~ person has made an informed refusal of a medical treatment designed to benefit ~~her~~ their fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the ~~woman~~ person entails a minimal invasion of ~~her~~ their bodily integrity, and would clearly prevent substantial and irreversible harm to ~~her~~ their fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances. (2) The physician's duty is to ensure that the pregnant ~~woman~~ person makes an informed and thoughtful decision, not to dictate the ~~woman's~~ person's decision. (3) A physician should not be liable for honoring a pregnant ~~woman's~~ person's informed refusal of medical treatment designed to benefit the fetus. (4) Criminal sanctions or civil liability for harmful behavior by the pregnant ~~woman~~ person toward ~~her~~ their fetus are inappropriate. (5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs."

f) RESOLVED, policy 390.005 be renamed "Parental/Fetal Conflict"

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1. The Human Rights Campaign Foundation. LGBTQ+ inclusive definitions of family. HRC Foundation. https://www.thehrcfoundation.org/professional-resources/lgbtq--inclusive-definitions-of-family. Accessed April 17, 2023.

2. The American College of Obstetricians and Gynecologists. Inclusive language: Statement of Policy. ACOG. https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/ 2022/inclusive-language. Published February 2022. Accessed April 17, 2023.
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RELEVANT AMA POLICY:

HIV/AIDS and Substance Abuse H-20.903
Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers; (2) advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers, especially homeless, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection. [CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13]

Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission H-20.918
In view of the significance of the finding that treatment of HIV-infected pregnant women with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements: (1) Given the prevalence and distribution of HIV infection among women in the United States, the potential for effective early treatment of HIV infection in both women and their infants, and the significant reduction in perinatal HIV transmission with treatment of pregnant women with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all women. The ideal would be for all women to know their HIV status before considering pregnancy. (2) Universal HIV testing of all pregnant women, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent. (3) The final decision about accepting HIV testing is the responsibility of the woman. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for the woman and her infant. (4) To assure that the intended results are being achieved, the proportion

of pregnant women who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of women accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success. (5) Women who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period. (6) When HIV infection is documented in a pregnant woman, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for her own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to her infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to herself and her infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for herself and her infant is the right and responsibility of the woman. When the woman's serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant. (7) Appropriate medical treatment for HIV-infected pregnant women should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the woman presents for prenatal or intrapartum care. (8) To facilitate optimal medical care for women and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both mother and infant. Ideally, this information will be included in the confidential medical records. Physicians providing care for a woman or her infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the mother and infant, consistent with applicable state law. (9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for women presenting in labor and for women presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both women and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms. (10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected women, should be maintained. [CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918

1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water. [Res. 428, A-16]

Reducing Lead Poisoning H-60.924

1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of

lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level >5 µg/dL (>50 ppb) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level >1 µg/dL (10 ppb).
3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 µg/dL (10 ppb).
4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply. [CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17]

Provision of Health Care and Parenting Classes to Adolescent Parents H-60.973

1. It is the policy of the AMA (A) to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses and (B) to support

programs directed toward increasing high school graduation rates, improving parenting skills and decreasing future social service dependence of teenage parents.
2. Our AMA will actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school. **[**Res. 422, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 422, A-13]

Humanitarian and Medical Aid Support to Ukraine D-65.984
Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22]

Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961
Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates. [CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

Addiction and Unhealthy Substance Use H-95.976
Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:
(1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction;
(2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to continue to support research and demonstration projects around effective prevention and intervention strategies;
(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
(7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. (BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Modified: CSAPH Rep. 01, A-19)

Mercury and Fish Consumption: Medical and Public Health Issues H-150.947
AMA policy is that: (1) Women who might become pregnant, are pregnant, or who are nursing should follow federal, state or local advisories on fish consumption. Because some types of fish are known to have much lower than average levels of methylmercury and can be safely consumed more often and in larger amounts, women should also seek specific consumption recommendations from those authorities regarding locally caught or sold fish. (2) Physicians should (a) assist in educating patients about the relative mercury content of fish and shellfish products; (b) make patients aware of the advice contained in both national and regional consumer fish consumption advisories; and (c) have sample materials available, or direct patients to where they can access information on national and regional fish consumption advisories. (3) Testing of the mercury

content of fish should be continued by appropriate agencies; results should be publicly accessible and reported in a consumer-friendly format. [CSA Rep. 13, A-04; Modified: Res. 538, A-05; Modified: CSAPH Rep. 1, A-15]

AMA Support for Breastfeeding H-245.982

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.
2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.
3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.
4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).
5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines. [CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18]

Accommodating Lactating Mothers Taking Medical Examinations H-295.861

Our AMA: (1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a

suitable environment during examinations to express milk; and (2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. [Sub. Res. 903, I-14; Modified: Res. 310, A-17]

Protecting Trainees' Breastfeeding Rights D-310.950
Our AMA will: (1) work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk; and (2) work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding mothers in regular program reviews. [Res. 302, I-16]

Post-Partum Hospital Stay and Nurse Home Visits H-320.954
The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the mother and of the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the mother and newborn. [Sub. Res. 105, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16]

Substance Use Disorders During Pregnancy H-420.950

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual’s family structure, (b) the patient’s treatment status, and (c) current impairment status when substance use is suspected. [Res. 209, A-18; Modified: Res. 520, A-19]

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs. [Res. 102, A-12; Modified: Res. 503, A-17]

Shackling of Pregnant Women in Labor H-420.957
1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:
   - An immediate and serious threat of harm to herself, staff or others; or
   - A substantial flight risk and cannot be reasonably contained by other means.

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."
2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. [Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20]

Perinatal Addiction - Issues in Care and Prevention H-420.962
Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of

funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care. Citation: [CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17; Reaffirmed: Res. 514, A-19]

Fetal Alcohol Syndrome Educational Program H-420.964
Our AMA supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant. [Res. 122, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant Women H-420.968
It is the policy of the AMA to communicate the available guidelines for testing all pregnant women for HBV infection. [Res. 19, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

Legal Interventions During Pregnancy H-420.969
Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women:
(1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.
(2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
(3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.
(4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.
(5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
(6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation. [BOT Rep. OO, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: Res. 507, A-16; Reaffirmed: Res. 209, A-18]

AMA Statement on Family and Medical Leave H-420.979
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:
(1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
(2) maternity leave for the employee-mother;
(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through

the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. [BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22]

Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women D-420.992
Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant women. [Res. 504, A-17]

Bonding Programs for Women Prisoners and their Newborn Children H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed directly and/or privately pump and safely store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. [CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Modified: Res. 431, A-22]

7.3.4 Maternal-Fetal Research
Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.
Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.
In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:
(a) Base studies on scientifically sound clinical research with animals and nongravid human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
(b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
(c) Obtain the informed, voluntary consent of the pregnant woman.
(d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman. (Issued: 2016)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: H
(A-24)

Introduced by:	RFS Governing Council
Prepared by:	RFS Committee on Medical Education
Subject:	Recognizing Moral Injury in Medicine as a Phenomenon Distinct from Burnout
Referred to:	Reference Committee

Introduction

At its 2023 Interim Meeting, your AMA-RFS Assembly considered resolution 5, entitled "Recognizing Moral Injury in Medicine as a Phenomenon Distinct from Burnout", which stated the following:

> RESOLVED, that our AMA study the issue of moral injury in medicine as a phenomenon distinct from burnout; and be it further
>
> RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at the 2023 Interim Meeting.

Based on your Reference Committee report, there was mixed testimony on this resolution. Your Virtual Reference Committee testimony was largely in support of the spirit of the resolution. However, opposition arose with the second resolved clause calling for "immediate forward" of the resolution. Your Reference Committee report was as stated below:

Your Reference Committee heard broad support for the spirit of Resolution 5. The most notable opposition was to the immediate forwarding clause, specifically in terms of meeting the timeliness and urgency threshold. Both AMA staff and your RFS member on the Council on Science & Public Health had concerns regarding the novelty of the resolution and whether current peer-reviewed literature supported these concerns. Our AMA has been at the forefront of advocating for systems-level solutions to burnout, including through the Joy in Medicine Health System Recognition Program, as well as studying contributors to burnout. For additional references of the work AMA is doing in this space, please refer to BOT-5: AMA Public Health Strategy: The Mental Health Crisis being presented at this meeting. Your Reference Committee agrees with testimony that an internal study looking specifically at trainees could produce more focused and comprehensive results, and/or a more relevant ask of the AMA if indicated. Therefore, your Reference Committee recommends that Alternate Resolution 5 be adopted in lieu of Resolution 5.

After additional debate and discussion, your RFS Assembly ultimately voted to adopt alternate resolution 5 in lieu of original resolution 5, which read as follows:

> RESOLVED, That our AMA-RFS study ways to mitigate the effects of moral injury and/or burnout amongst medical students, residents, fellows, and other trainees in the US.

This resolution calling for study was forwarded to your RFS Governing Council, which, based on the subject matter of moral injury and burnout that may occur during graduate medical education, referred it to your RFS Committee on Medical Education.

The following report "Recognizing Moral Injury in Medicine as a Phenomenon Distinct from Burnout," will first begin with background on burnout and moral injury, including definitions for both entities, their similarities, and, more importantly, their distinctness. These entities will then be applied to the field of medicine and how they might define or potentially be limited in capturing the experience of physicians and trainees. We will review current policies from our AMA and our AMA-RFS that concern both burnout and moral injury and identify any potential gaps in policy. Finally, given the context of the adopted resolution and its associated discussion within our RFS Assembly, we will proffer recommendations that seek to recognize the importance of this topic within existing and potential policy.

Background

Moral injury (MI), first defined in the military context, refers to the distress felt due to repeated insults to one's morality and beliefs. MI is caused by repeatedly experiencing potentially morally injurious events (PMEIs). While this is seen in the military, it more frequently leads to cumulative MI in healthcare. MI describes the problems faced in healthcare that are beyond our control. The source of distress, unlike burnout, is the system, not the individual.

Defining Moral Injury and Burnout

Our understanding of moral injury comes from the fields of ethics and morality, and its application in healthcare requires a thorough examination of its definition. The term was initially used in military populations to describe a situation where a betrayal of what is right occurs, either by oneself or a person of authority in a high-stakes environment, resulting in psychological trauma[1,2]. Over time, this definition has evolved to include all "transgressive harms and the outcomes of those experiences"[2,3] and has been applied to other fields, including healthcare. The continuous exposure to PMIEs leads to cumulative, long-lasting psychological trauma due to "perpetrating, failing to prevent or bearing witness to acts that transgress deeply held moral beliefs and expectations"[4,5].

On the other hand, social and clinical psychology has extensively researched burnout syndrome and most of its applications in healthcare are based on this work. Burnout syndrome describes the response to chronic interpersonal stressors at work and is characterized by exhaustion, cynicism, and detachment[6].

Moral injury and burnout are intertwined concepts in healthcare and can often occur synchronously. The psychological trauma resulting from PMIEs often creates and exacerbates chronic aggression and interpersonal stressors in the healthcare setting. Failure to establish clear strategies to halt these experiences inevitably leads to healthcare workers' exhaustion, cynicism, and detachment.

Application of Burnout to Physicians and Trainees

Burnout in the healthcare field has become a prevalent topic, especially in light of the COVID-19 pandemic. Given this and the current healthcare landscape, this topic will likely continue to remain in the spotlight. With the increase in the prevalence of this topic's discussion, more research is being done specifically to highlight trainee and physician burnout.

A study done on ACP members in 2020 reported that while many physicians had career satisfaction, over 50% reported burnout associated with lack of work control and documentation pressures[10]. Similarly, a meta-analysis covering 48 studies assessing trainee burnout reported that factors such as concerns about patient care, work demands, and poor work environment

favored burnout[11]. The study also concluded that demands outside of work may contribute, such as poor health, but these likely played a smaller role in burnout than the workplace-related factors[11]. These studies also showed that female physicians were at higher risk[10,11,12].

The consequences of burnout can be dire, with physicians suffering from burnout more likely to report professionalism issues, depression, and suicidal ideation, as well as worse patient outcomes[12,13,15]. This is of concern to those within the healthcare profession and to society as a whole.

A quick literature search shows how prevalent this topic is and how the research is multiplying yearly. Study after study concludes that burnout is a worse problem in physicians[12] than in most other occupations and is almost always related to workplace issues and stressors[10,11,14,15]. This is of huge concern to the future of physicians and medicine.

Application of Moral Injury to Physicians and Trainees

As physicians, we enter healthcare to help people and save lives. However, recurrently failing to meet these goals after years of sacrifice induces moral injury. Given the landscape of healthcare as a profit-driven industry, physicians' medical decision-making is affected by a multitude of factors beyond simply "what is best for the patient." They are limited by resources, funds, and, most importantly, time[7].

In healthcare, MI came to the forefront during the COVID-19 pandemic. MI in healthcare is associated with higher rates of burnout and psychological distress. This has been studied extensively and has been found to affect healthcare workers on the emotional, psychological, and spiritual levels. PMEIs affecting healthcare workers exist at the systemic and individual levels. At the systemic level, examples include understaffing, navigating the fragmented health care system, encountering significant health inequities and injustices, and lack of resources, exacerbated during the Covid-19 pandemic. Individual factors include risk or unethical treatments. Often, individual MI is exacerbated by systemic MI. With chronic understaffing, healthcare workers worked longer hours and saw more patients8. Healthcare workers are not well-trained to manage exposure to PMIE. Meanwhile, the military uses evidence-based protective factors such as unit cohesion and supportive leadership.

Current relevant AMA and AMA-RFS Policy

The AMA and AMA-RFS have the following relevant policies: 281.024R, 291.015R, 291.036R, and AMA Policies D-310.968, H-405.948, and D-405.972. These policies aim to improve medical trainees' well-being and career satisfaction through financial support, burnout management strategies, institutional backing, and systemic reforms.

Financial concerns and equitable compensation are central to the AMA-RFS policy stance, as exemplified in Resolution 281.024R, which underscores the significant student debt burden on physicians compared to other health professionals. This policy advocates for studies on financial disincentives to entering the medical profession, fair compensation for resident physicians, and the economic contributions of resident physicians to healthcare institutions. It aims to inform advocacy efforts by comparing career satisfaction metrics across healthcare professions, highlighting the need for financial equity in the medical field.

Resolutions 291.015R and 291.036R directly address burnout recognition, treatment, and prevention, emphasizing the importance of studying resident burnout to develop effective strategies for its recognition, treatment, and prevention. These strategies include incorporating burnout management into residency program requirements, promoting mindfulness education as outlined in AMA Policy D-310.968, and developing organizational strategies to mitigate

physician demoralization and promote overall well-being, as mentioned in AMA Policy D-405.972.

Institutional and organizational support is a key focus, with AMA Policy D-310.968 encouraging collaborations with accrediting bodies and medical organizations to address burnout comprehensively. Furthermore, AMA Policy D-405.972 advocates for the inclusion of physician well-being as an accreditation standard, emphasizing system-wide interventions that do not impose additional burdens on physicians.

AMA Policy D-310.968 commits to continuous monitoring of burnout issues and encourages the dissemination of research findings to the medical community. This is complemented by the call for anonymous surveys to identify factors contributing to physician demoralization, aiming to implement feedback-based organizational changes.

Unique challenges trainees face, such as debt, inequitable compensation, discrimination, and long work hours, are recognized in AMA Policy H-405.948, which advocates for these factors to be considered in measuring physician well-being. System-wide interventions to enhance physician well-being, including removing intrusive credentialing questions related to health, are supported by AMA Policy D-405.972.

In summary, the AMA and AMA-RFS have laid out a detailed policy framework, encompassing Resolutions 281.024R, 291.015R, 291.036R, and AMA Policies D-310.968, H-405.948, and D-405.972, aimed at improving the well-being and career satisfaction of medical trainees through a combination of financial support, burnout management strategies, institutional backing, and systemic reforms.

Discussion

Limitations of current AMA and AMA-RFS policy

As it stands, the current AMA and AMA-RFS policy's biggest limitation is inherently a strength. The policy asks for support, funding, research, and collaboration with other interested parties. There are no firm actions in the policy, but this allows more liberty to be taken to help address the present and growing issue of physician burnout.

Rationale for Policy Recommendations

The Resident and Fellow Section Committee on Medical Education reviewed and analyzed current RFS and AMA policy, understanding the concerns of its members. The RFS and AMA have ample policies supporting and researching ways to improve physician burnout. Our current policy will continue to help reduce burnout across disciplines. We wish to thank the authors and recognize their passion and desire to reduce physicians' emotional strain. With that in mind, your committee wants to recognize the addition of moral injury and its personal and individualized role to each physician, trainee, and student effect on burnout. Our policy will reflect this as well.

Recommendations

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

1. That our AMA-RFS recognizes that moral injury plays a significant and individualized role in the development of physician and trainee burnout.
2. That our AMA-RFS reaffirm internal policy of 281.024R and 291.036R.
3. That our AMA-RFS amend AMA-RFS policy 291.015R by addition and deletion to read as follows:

291.015R Intern and Resident Burnout
That our AMA-RFS support studying resident burnout to determine: (1) if recommendations can be made on how to recognize burnout, how to treat it, and, if possible, how to prevent it; (2) if it relates to the professionalism core competency for residents; ~~and~~ (3) if recognizing, treating, and possibly preventing burnout could be included in the program requirements for residency program directors~~.~~; and(4) recognize that moral injury is an important factor in the development of burnout.

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RELEVANT RFS POSITION STATEMENTS:

281.024R Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals: That our AMA-RFS support that the AMA's advocacy efforts are informed by the fact that student debt burden is higher for physicians when compared to physician assistants and nurse practitioners; and That our AMA work with relevant stakeholders to study: a) How total career 38 AMA-RFS Digest of Actions earnings of physicians compare to those physician assistants and nurse practitioners in order to specifically discern if there is a financial disincentive to becoming a physician, considering the relatively high student debt burden and work hours of physicians; b) If resident physicians provide a net financial benefit for hospitals and healthcare institutions; c) Best practices for increasing resident physician compensation so that their services may be more equitably reflected in their earnings; d) Burnout metrics using a standardized system to compare differences among physicians, physician assistants and nurse practitioner; and That our AMA recognize that burnout-centered metrics do not fully characterize work-life balance particularly for individuals with varying socioeconomic, racial, and/or sexual minoritized backgrounds; and That our AMA seek to publish its findings in a peer reviewed medical journal. (Report C, A-22)

291.015R Intern and Resident Burnout: That our AMA-RFS support studying resident burnout to determine: (1) if recommendations can be made on how to recognize burnout, how to treat it, and, if possible, how to prevent it; (2) if it relates to the professionalism core competency for residents; and (3) if

recognizing, treating, and possibly preventing burnout could be included in the program requirements for residency program directors. (Resolution 3, A-06) (Reaffirmed Report D, I-16)

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

RELEVANT AMA POLICY:

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.
8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being. [CME Rep. 8, A-07 Modified: Res. 919, I-11 Modified: BOT Rep. 15, A-19 Reaffirmation: A-22]

Factors Causing Burnout H-405.948
Our AMA recognizes that medical students, resident physicians, and fellows face unique challenges that contribute to burnout during medical school and residency training, such as debt burden, inequitable compensation, discrimination, limited organizational or institutional support, stress, depression, suicide, childcare needs, mistreatment, long work and study hours, among others, and that such factors be included as metrics when measuring physician well-being, particularly for this population of physicians. [Res. 208, I-22]

Physician Burnout D-405.972
Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications. [Res. 723, A-22; Reaffirmation I-22]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: I
(A-24)

Introduced by: Anna Heffron, MD, RFS Delegate, and Joey Whelihan, MD, RFS Alternate Delegate

Subject: Sunset Mechanism (2013)

Referred to: Reference Committee

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

Due to a change in standards of nomenclature in the updated IOPs, all resolutions archived in the Digest of Actions shall state “Our AMA-RFS” and shall henceforth be referred to as “internal position statements.” The appendix of this report contains a list of recommended actions regarding internal position statements last reviewed from the RFS 2013 fiscal year, as well as other relevant or associated outdated positions. Positions considered outmoded, irrelevant, duplicative and inconsistent with more current positions will have specific recommendations. For each internal position statement under review, this sunset report recommends whether to: (1) rescind; (2) reaffirm; (3) reconcile with more recent actions; or (4) reaffirm with editorial changes, which constitutes a first order motion. A succinct justification for each recommendation will be provided. Due to the IOP change, all existing statements not up for review on the sunset calendar, or that do not require reconciliation, will be updated with editorial changes in the Digest of Actions, but will not be reset on the sunset calendar and are not included in the Appendix of this report.

Each individual item may be extracted from the report to be discussed by the General Assembly, but only in the frame of adopting or not adopting the original recommendation as additional amendments will not be allowed from the floor. Any action that retains or updates an item resets the sunset timeline. Defeated sunset recommendations extend the item for one year, to be reconsidered in the next academic year.

Of note, at the Annual 2023 Meeting adopted two resolutions, “Updating Language Regarding Families and Pregnant Persons” and “Editorial Changes to Outdated and Stigmatizing Language in the RFS Digest of Actions,” which together direct the RFS to update its policy Digest to remove and replace gendered, discriminatory, and stigmatizing language. Efforts have been made to address those effects in this Sunset Report.

This information was presented to the Assembly at the November 2023 Interim Meeting in the form of an informational report to allow ample time for delegates to consider these initial recommendations. Any concerns or objections from the informational report have been amended in this final version of the Sunset Report.

APPENDIX
RECOMMENDED ACTIONS ON 2013 RFS POSITIONS

Policy No.	Title	Text	Recommendation
291.019R	Resident/Fellow Work and Learning Environment	That: (1) our AMA-RFS define resident duty hours as those scheduled hours associated with primary resident or fellowship responsibilities; (2) our AMA-RFS support a limit on resident duty hours of 84 hours per week averaged over a two-week period; (3) our AMA-RFS support on-call activities no more frequent than every third night and there be at least one consecutive 24 hour duty-free period day every seven days both averaged over a two-week period; (4) our AMA-RFS support a standard workday limit for resident physicians of 12 hours. Patient care assignments exceeding 14 hours are considered on-call activities; (5) our AMA-RFS support a limit on scheduled on-call assignments of 24 consecutive hours. On-call assignments exceeding 24 consecutive hours must end before 30 hours. The final 6 hours of this shift are for education, patient follow-up, and transfer of care. New patients and/or continuity clinics must not be assigned to the resident during this 6-hour period; (6) our AMA-RFS support the inclusion of home call hours in the total number of weekly scheduled duty hours if the resident on call can routinely expect to get a less than 5 consecutive hours of sleep; (7) our AMA-RFS support a limit on assignments in high intensity settings of 12 scheduled hours with flexibility for sign off activities; (8) our AMA-RFS support that limits on duty hours must not adversely impact the organized educational activities of the residency program; (9) our AMA-RFS encourage the AMA to ask the ACGME to establish new requirements for mandatory and protected education time in residency programs that constitutes no less than 10% of scheduled duty hours; (10) our AMA-RFS support that scheduled time providing patient care services of limited or no educational value be minimized; (11) our AMA-RFS encourage the AMA to ask the Joint Commission on the Accreditation of Hospital Organizations (JCAHO) to create new resident work	Reaffirm with editorial changes. This policy was already sent to the House of Delegates and was modified to become *Resident/Fellow Clinical and Educational Work Hours H-310.907*. Editorial edits clarify that this is now internal policy.

		condition standards that require institutions to provide minimum ancillary staffing levels (e.g. 24 hour phlebotomy, transport services, etc.) at institutions that train physicians; (12) our AMA-RFS encourage the AMA to ask JCAHO to establish reporting mechanisms and sanctions that increase hospital accountability for violations of resident work condition standards; and (13) our AMA-RFS support the AMA Council on Legislation as the coordinating body in the creation of legislative and regulatory options. (Report F, A-02) (Reaffirmed Report D, I-12) [See also: CME Report 9, A-02]	
580.016R	GME Delegates	Recommended (1) that a system for establishing the number of, the selection process for, and the caucusing and seating arrangements of GME Delegates be outlined by the AMA-RFS Governing Council through collaboration with the CLRP as part of a "pilot project"; and (2) that a report be presented to the Assembly at I-12 but no later than A-13. (Report F, A-12)	Rescind. The asks of this policy have been completed. The report requested was presented to A-13 and can be found here.
160.008R	Health Insurance Carriers Cancelling Coverage for Thousands of Patients	That our AMA-RFS support: (1) allowing individual subscribers to health insurance plans that were not in compliance with the Affordable Care Act (ACA), and who therefore experienced cancellations of their health insurance, be able to renew their recently cancelled insurance contracts for one year; (2) working with other interested stakeholders to delay penalties for non-insurance under the ACA for one year and extend the deadline to enroll for insurance under the ACA for one year, only for those who experienced cancellations of their individual health insurance due to noncompliance with the ACA; and (3) working with other interested stakeholders to help implement fixes to the ACA that will help individual subscribers to health insurance plans that were not in compliance with the ACA and who therefore experienced cancellations of their health insurance. (Emergency Resolution 1, I-13)	Reaffirm with editorial changes.
170.006R	Regulating Residency and Fellowship Positions	That our AMA-RFS: (1) Governing Council summarize emerging legislative issues affecting physician workforce planning for as long as is appropriate; (2)	Reaffirm.

		support state medical societies providing summaries to the AMA of emerging legislative issues affecting physician workforce planning in their states. (Substitute Resolution 13, I-93) (Reaffirmed Report C, I-03) (Reaffirmed Report D, I-13) [See also: Governing Council Report D, A-94]	
170.009R	Addressing the Physician Workforce Shortage by Increasing GME Funding	That our AMA-RFS: (1) work with the AMA and in consultation with interested stakeholders to develop a comprehensive framework for a sustainable GME financing plan that addresses the physician workforce shortage and could be implemented at both the state and federal levels; and (2) work with the AMA to support pilot projects supported through state and federal funding in medically under-served areas that foster resident training programs, offer loan repayment, and support independent practice development as a means to address the physician workforce shortage. (Late Resolution 1, A-13) [CME Report 5, I-13]	Reaffirm.
170.010R	Graduate Medical Education Funding and Quality of Resident Education	That our AMA-RFS support innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the ACGME. (Resolution 4, A-13) [HOD Resolution 304, A-14]	Reaffirm.
180.001R	Safety of Healthcare Professionals in the Workplace	That our AMA-RFS support the AMA working with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Occupational Safety and Health Agency (OSHA), Committee of Interns and Residents (CIR), or other appropriate agencies to ensure the protection of healthcare professionals from violence in the workplace. (Substitute Resolution 5, A-03) (Reaffirmed Report D, I-13) [AMA policy reaffirmed in lieu of RFS Substitute. Res. 5, I-03; See: AMA Policy H-215.977 Guns in Hospitals and H-215.978 Guns in Hospitals]	Reaffirm.
190.001R	Establishment of Housestaff Associations	That our AMA-RFS encourage state resident physicians sections to: (1) disseminate information on starting housestaff organizations; (2) offer	Reaffirm.

		assistance to housestaffs requiring it and afford them access to AMA-RFS staff; and (3) visit local housestaffs and discuss the benefits of forming an organized body. (Substitute Resolution 11, I-83) (Reaffirmed Report C, I-93) (Reaffirmed Report C, I-03) (Reaffirmed Report D, I-13)	
220.001R	Employment of Non-Certified International ~~Foreign~~ Medical Graduates	That our AMA-RFS: (1) oppose efforts to employ graduates of international ~~foreign~~ medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met State criteria for full licensure, and (2) support states that have difficulty recruiting doctors to underserved areas exploring the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs. (Resolution 2, A-03) (Reaffirmed Report D, I-13) [Current AMA policy reaffirmed in lieu of AMA Resolution 206, A-03; AMA Resolution 309 adopted in lieu of Resolution 319 brought by RFS.]	Reaffirm with editorial changes. Updated language to be more in line with current use including current use of the International Medical Graduate Section.
230.008R	Exemption of Fellows from Requirements of Physician Payment Sunshine Act	That our AMA-RFS support CMS using the AMA definition of a “Resident” when formulating rules and regulations. (Late Resolution 3, I-13)	Reaffirm.
240.004R	Assessment and Regulation of Procedural Competency	That the AMA-RFS support specialty societies determining where minimum frequency standards for procedural competency are appropriate and develop those standards. (Resolution 11, I-03) (Reaffirmed Report D, I-13)	Reaffirm.
240.013R	Impaired Physicians	That our AMA-RFS support: (1) prevention and treatment of medical student, resident, and fellow physician impairment and when feasible, reentry into medical school or residency and fellowship programs; (2) residents being included as members and proponents of impairment committees in states where housestaff serves on such bodies; and (3) residents ~~to~~ seeking membership on impairment committees in states where no such representation exists. (Report D, A83) (Reaffirmed Report C, I-93) (Reaffirmed Report C, I-03) (Reaffirmed Report D, I-13)	Reaffirm with editorial changes.
260.016R	Providing	That our AMA-RFS support: (1)	Reaffirm with editorial

	Residency Applicants a Timely Response to Residency Application Outcome	residency and fellowship programs ~~to~~ incorporating interview dates increased flexibility, whenever possible, to accommodate applicants' schedules; (2) the ACGME and other accrediting bodies ~~to~~ require<u>ing</u> programs to provide, by electronic or other means, representative contracts to applicants prior to the interview; and (3) residency and fellowship programs informing 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]	changes.
281.007R	Student Loan Interest Rates	That our AMA-RFS support legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 6.8%. (Amended Resolution 3, A-03) (Reaffirmed Report D, I-13) [HOD Resolution 316, A-03]	Reaffirm.
281.022R	Protecting Residents Against Avoidable Financial Constraint Related to Reimbursed Work-Related Expenses	That our AMA-RFS support: (1) training programs evaluating their own institution's process for repayment and develop a leaner approach, including disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; (2) a system of expedited repayment for purchases of $200 or less, for example through payment directly from their programs (in contrast to following traditional workflow for reimbursement); and (3) training programs developing 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 is strongly recommended in advance but at a minimum, reimbursement should be completed at 2 weeks and not to exceed 1 month after submission of relevant reimbursement documents), and unplanned expenses which includes money spent collective above the planned amount by trainees is strongly recommended to be reimbursed by 1 month after submission of relevant reimbursement documents, with a period	Reaffirm.

		not to exceed 6 weeks. (Late Report F, I-13) [HOD Resolution 303, A14]	
291.016R	Resident/Fellow Work and Learning Environment	That our: ~~(1) AMA ask the Board of Directors of the Accreditation Council for Graduate Medical Education (ACGME) to reconsider the changes made in the Common Program Requirements for duty hours and the procedures for the approval exemptions at their meeting of February 11, 2003, and approve the original language and intent from June 2002 prior to the implementation of requirements on July 1, 2003; (2) AMA study all options to address enforcement and compliance with the ACGME Duty Hour requirements (JCAHO, legislation, private methods etc) with a report back to the House of Delegates at the A-04 meeting;~~ (1~~3~~) AMA-RFS support the AMA in AMA studying, developing, and promote~~d~~ing a method of creating an environment for residents to safely report violations on resident duty hours without any repercussions; (2~~4~~) AMA-RFS support the AMA in requesting an annual report to ACGME's Member Organizations from the ACGME, which includes the number of complaints received, the number not in compliance due to duty hours and working conditions and the action taken by ACGME, and that this report be indexed by specialty; (3~~5~~) AMA-RFS support our AMA in continue~~d~~ing to work with the ACGME to refine the duty hours standards, and working with ACGME and other appropriate entities to collect evidence on the impact of current standards in regards to patient and resident safety, resident education, and eliminating fatigue and sleep deprivation; (4~~6~~) AMA-RFS support the program module developed by the American Academy for Sleep Medicine to educate residency training programs on sleep deprivation and fatigue that is scheduled to be ready for distribution by July 1, 2003; (5~~7~~) AMA-RFS and the AMA-MSS continue working with groups such as the Committee of Interns (CIR) on collaborative efforts to see that duty hour reform is enforced and continue to work to improve working conditions for residents and fellows; (6~~8~~) That our	Reaffirm in part with editorial changes. Rescind current Parts (1, 2). Rescind current (1) since it is asking for action on a meeting which occurred in 2003. Rescind current (2) since it is asking for a report which was generated at a past meeting (reports from 2004 are not available online currently so we cannot link this report here). Of note, part (8) of the original policy was not accomplished by the House of Delegates. Your RFS Governing Council will follow up with AMA leadership to determine whether a 10-year survey can be completed.

		AMA-RFS support our AMA in conducting a 10-year survey to capture the attitudes and changes of residents on duty hours after the new ACGME guidelines to determine the effect on working conditions for residents and fellows;(7~~9~~) That our AMA-RFS reaffirm policy H.310.928 and D. 310.999 by encouraging the Agency for Healthcare Research and Quality (AHRQ) to examine the link between resident work hours and patient safety in order to find solutions to the problems. (Report F, A-03) [HOD Resolution 322, A-03] (Reaffirmed Report D, I-13)	
292.001R	Amending the ACGME Residency Due Process Requirements	That our AMA-RFS support the amendment of the ACGME's Institutional Requirements to specifically require that institutional grievance policies governing the dismissal or non-renewal of a resident or fellow include the following principles, in writing: 1. Notification must be issued to a resident when disciplinary action is to be taken, the reasons for the adverse action, a detailed outline of the due process procedure, including the resident's rights, if applicable, to a hearing and any time limitation for an appeal to the action; 2. If the action involves the non-promotion, contract non-renewal, or dismissal of a resident, the appellate process must include the right to a fair, objective, and independent hearing before a multi-person review committee, during which the resident should be entitled to present a defense to the charges against ~~him or her~~ them; 3. Review committees should be comprised of physicians and include a consequential number of persons at a similar level of training as the aggrieved resident to judge whether the actions of the resident were reasonable based on the perception of a fellow trainee similarly situated; 4. Review committees should not include any person directly involved in the circumstances surrounding the incident(s) giving rise to the action against the resident; 5. All material information obtained by the review committee regarding the subject of the review hearing should be	Reaffirm with editorial changes. Per RFS Policy 550.010R, this policy has been updated to use non-gendered language.

		made available to the resident, or ~~his or her~~ their attorney, in a timely manner prior to the hearing; 6. Program directors and residents should have the right to be represented by an attorney during review hearings. Program directors, residents, or their respective attorneys should be permitted to call and examine/cross-examine witnesses and present evidence during the review hearing; 7. Program directors, residents, or their respective attorneys should receive a written statement of the review committee's recommendation and the basis for the decision; 8. Residency program disciplinary policies should state whether a resident will continue to receive their compensation pending a final decision on any disciplinary action; 9. Residency program disciplinary policies should include a reasonable process by which residents can obtain their training record for any reason. (Report E, I-13)	
294.015R	Simulation: An Educational Tool for Training and Skill Maintenance	That our AMA-RFS support encouraging medical schools and teaching hospitals to incorporate simulation as an educational tool and develop ways in which it could become a method of evaluating medical student/physician performance. (Resolution 2, A-13)	Reaffirm.
300.002R	Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients	That our AMA-RFS (1) support policies that allow for a change of sex designation on birth certificates for transgender individuals ~~based upon verification by a physician that the individual has undergone gender transition according to applicable medical standards of care~~; (2) support eliminating any government requirement that an individual have undergone surgery in order to change the sex designation on birth certificates; and (3) support that any change of sex designation on an individual's birth certificate not hinder access to medically appropriate preventative care. [HOD Resolution 004, I-13]	Reaffirm and partly rescind. The partial recission in (1) is due to a more recent adoption of a policy (130.017R Affirming the Medical Spectrum of Gender) which conflicts with and thus supersedes this policy.
340.005R	Medical Errors and Physician Standards	That our AMA-RFS support: (1) educating patients and the general public on efforts to improve quality and reduce errors in the delivery of medical care; (2)	Reaffirm.

		ethical obligations of physicians to report impaired, incompetent, and unethical colleagues; (3) the AMA stating its commitment to uphold the highest ethical standards in the clinical, research, and administrative practices of physicians; (4) the AMA, through its medical liability reform campaigns, continuing to emphasize both professionalism in medicine and the importance of reducing medical errors. (Resolution 1, A-03) (Reaffirmed Report D, I-13)	
350.002R	Increasing Diversity in the Medical Profession	That our AMA-RFS: (1) encourage its members to participate in mentoring and role-modeling programs such as the AMA ~~MAC's~~ Minority Affairs Section (MAS)'s Doctors Back to School Program in order to attract more ~~underrepresented minority~~ students from historically marginalized groups towards the medical profession; and (2) support efforts to eliminate racial and ethnic health care disparities. (Resolution 6, I-03) (Reaffirmed Report D, I-13)	Reaffirm with editorial changes. The Minority Affairs Caucus is now the Minority Affairs Section. Update this policy's language to be in accordance with the AMA's health equity language guide. If interested, mentioned program still exists and is linked here.
380.008R	Physicians Privacy Protection	That the AMA-RFS support that: (1) the AMA petition the Federation Credentials Verification Service (FCVS) to replace language in their affidavit and release form with a specific and limited list of information for which the FCVS is responsible for gathering and verifying; (2) the authorization of the FCVS to gather information pertaining the applicant should be terminated when no profile forwarding requests are pending and the affidavit should describe the right of the applicant to withdraw the authorization at any time; and (3) the FCVS is petitioned to remove clauses from the affidavit and authorization for release of records which deny the applicant legal recourse in the event that the FCVS or other parties cause injury through the careless, negligent, or otherwise inappropriate handling of the physician's private information. (Resolution 8, A-03) (Reaffirmed Report D, I-13) [HOD Resolution 318, A-03)	Reaffirm.
420.001R	Comprehensive Access to Safety Data from Clinical Trials	That our AMA-RFS support: (1) the Federal Drug Administration ~~to~~ investigating and developing means by which investigators can access original source safety data from clinical drug,	Reaffirm with editorial grammatical changes.

		biologic, and device trials; and (2) encouraging the adoption of a universal policy by medical journals requiring independent access to source study data from clinical drug, biologic, and device trials. (Report G, I-13) [HOD Resolution 503, A-14]	
500.010R	Policy-making Meetings for MSS and RFS	That our AMA-RFS support one policy making meeting per year for the AMA-HOD. (Emergency Resolution 1, A-13)	Rescind. It is unclear what this policy was intended to do, and further there is no record of it in the RFS policy digest or Reference Committee records since it was an emergency resolution. Currently, the AMA conducts two national policy-making meetings yearly, and the RFS attends and participates in both.
550.008R	2013-2016 Working Plan	Our AMA-RFS asks ~~Asked~~ that: In the realm of National Meetings: (1) The RFS Governing Council should work with the AMA to encourage RFS participation between meetings and that: a) the RFS should continue to work to ensure that the MSS/RFS research poster symposia continues to be held at a national meeting, b) the RFS Governing Council will continue to work with staff to increase resident and fellow attendance at leadership training events, including the National Advocacy Conference and AMA leadership retreats; (2) The RFS Governing Council should continue to improve the process of election procedures to ensure adequacy, transparency and integrity of the results; (3) The RFS Governing Council should continue to work to improve content at national meetings that will be relevant to members and that will engage them in the core areas of AMA involvement, Advocacy, Public Health, Community Service, Legislative Policy, Leadership Development and Membership. In the realm of Advocacy: (4) The RFS should continue to make preserving and improving GME funding and addressing future physician workforce issues a key priority of our advocacy actions; (5) The RFS Governing Council should continue	Reaffirm with editorial grammatical changes. RFS Regions are no longer part of the RFS structure and thus the passage involving RFS Regions has been rescinded. Further, a repeat report will be requested of the AMA-RFS CLRPD from the AMA-RFS Governing Council, pursuant to the asks of this policy.

		to annually identify key issues and mobilize the grassroots network to involve our section in advocating for RFS friendly positions on said issues and continue to educate the general assembly on these issues; (6) That the RFS should continue to work with other resident and fellow based organizations to ensure that the RFS serve as the national spokesperson for all resident and fellow centered issues including student debt, graduate medical education, medical licensure, and resident work hours. In the realm of Membership and Outreach: (7) The RFS and RFS Governing Council should investigate mechanisms to increase retention of members as they transition from one section to another, including: a) members transitioning from the MSS to RFS, b) members transitioning from the RFS to the YPS, and c) members transitioning out of ~~IPM programs~~GME Competency Education Program (GCEP); (8) The RFS should continue to work with the MSS And the YPS to improve mentoring strategies and increase mentoring opportunities such as combined networking events, mentoring panels, combined working groups and specific events targeted by specialty, year, or location; (9~~) The RFS should continue to examine and improve the role of the regions within the RFS, which should include: a) current contact information for region leadership and their contact information available online for access by members; b) the current level of activity in each region and ways to increase involvement; c) the roles and responsibilities of the region leadership; d) novel ways to improve communication, foster leadership and increase membership; e) collaboration with MSS and YPS Sections, including joint region meetings and community service events; (10~~) The RFS Governing Council should work to establish local membership liaisons that will work directly with GME programs to reach out to residency programs and recruit members; (11~~0~~) The RFS Should	

		continue to work with AMA membership staff to assist with planning local membership recruitment programs and coordinate the involvement of local RFS leaders in said programs; and (1~~2~~1) RFS leaders should continue to encourage Section participants to introduce the Introduction to the Practice of Medicine program to their relevant academic and medical center faculty. In the realm of Communication: (1~~3~~2) The RFS and R~~V~~FS Governing Council should work to establish online social media portals to encourage involvement in RFS activities and increase RFS awareness; (14~~3~~) The RFS Governing Council should investigate methods to ensure there is effective communication with the region leadership on a regular basis; (15~~4~~) the RFS Governing Council should establish a mechanism to provide Governing Council updates and direct communication to our membership and work with AMA staff to ensure that these updates be disseminated to all RFS members; and (16~~5~~) The RFS Governing Council should actively work to increase utilization of the RFS listserv and make it available to new members. In general, the RFS Committee on Long Range Planning recommends that: (17~~6~~) the RFS recommend that a Working Plan be developed by the Committee on Long Range Planning for the RFS Governing Council and approved by the assembly at least every 3 years. (Late Report H, I-13)	
580.017R	AMA-RFS 2013-2016 Working Plan	In the Realm of National Meetings: 1. The RFS Governing Council should work with the AMA to encourage RFS participation in a second business meeting to occur after the annual between meetings and that: a. The RFS should continue to work to ensure that the MSS/RFS research poster symposia continues to be held at a national meeting; b. The RFS Governing Council will continue to work with staff to increase resident and fellow attendance at leadership training events, including the National Advocacy Conference and AMA leadership retreats;	Rescind. Accidental duplication of 550.008R.

		2. The RFS Governing Council should continue to improve the process of election procedures to ensure adequacy, transparency and integrity of the results; 3. The RFS Governing Council should continue to work to improve content at national meetings that will be relevant to members and that will engage them in the core areas of AMA involvement, Advocacy, Public Health, Community Service, Legislative Policy, Leadership Development and Membership; In the realm of Advocacy: 4. The RFS should continue to make preserving and improving GME funding and addressing future physician workforce issues a key priority of our advocacy actions; 5. The RFS Governing Council should continue to annually identify key issues and mobilize the grassroots network to involve our section in advocating for RFS friendly positions on said issues and continue to educate the general assembly on these issues; 6. That the RFS should continue to work with other resident and fellow based organizations to ensure that the RFS serve as the national spokesperson for all resident and fellow centered issues including student debt, graduate medical education, medical licensure, and resident work hours. In the realm of Membership and Outreach: 7. The RFS and RFS Governing Council should investigate mechanisms to increase retention of members as they transition from one section to another including: a. Members transitioning from MSS to RFS; b. Members transitioning from the RFS to the YPS; c. Members transitioning out of IPM programs; 8. The RFS should continue to work with the MSS and the YPS to improve mentoring strategies and increase mentoring opportunities such as combined networking events, mentoring panels, combined working groups and specific events	

		targeted by specialty, year or location; 9. The RFS should continue to examine and improve the role of the regions within the RFS, which should include: a. Current contact information for region leadership and their contact information available online for access by members; b. The current level of activity in each region and ways to increase involvement; c. The roles and responsibilities of the region leadership; d. Novel ways to improve communication, foster leadership and increase membership; e. Collaboration with MSS and YPS Sections, including joint region meetings and community service events; 10. The RFS Governing Council should work to establish local membership liaisons that will work directly with GME programs to reach out to residency programs and recruit members; 11. The RFS should continue to work with AMA membership staff to assist with planning local membership recruitment programs and coordinate the involvement of local RFS leaders in said programs; 12. RFS leaders should continue to encourage Section participants to introduce the Introduction of the Practice of Medicine program to their relevant academic and medical center faculty; In the realm of Communication: 13. The RFS and RFS Governing Council should work to establish online social media portals to encourage involvement in RFS activities and increase RFS awareness; 14. The RFS Governing Council should investigate methods to ensure there is effective communication with the region leadership on a regular basis; 15. The RFS Governing Council should establish a mechanism to provide Governing Council updates and direct communication to our membership and work with AMA staff to ensure that these updates be disseminated to all RFS members; 16. The RFS Governing Council should actively work to increase utilization of the	

		RFS list-serve and make it available to new members; In general, the Committee recommends that: 17. The RFS recommend that a Working Plan be developed by the Committee on Long Range Planning for the RFS Governing Council and approved by the assembly at least every 3 years. (Late Report H, A-13)	

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1
(A-24)

Introduced by: Leanna (Leif) Knight, MD, Gabriel Walk, MD, Cristina Marsocci, MD, Aquila Brown Chase, MD, Rachel Ekaireb, MD, Zoe Warczak, MD

Subject: Reparative Work Addressing the Historical Injustices of Anatomical Specimen Use

Referred to: Reference Committee

Whereas, in the wake of the recent Harvard Anatomical Donation scandal, there is a clear need to reform rules and regulations surrounding the use of anatomical specimens in medical education, anthropological study, and related disciplines; and [1,2,3]

Whereas, America has a long and well-documented history of exploitation against Indigenous Americans, Alaska Natives, people of color, immigrants, those with disabilities, incarcerated people, non-Christian, and poor citizens, who historically have not been afforded the same rights as white, able-bodied Americans; and [4-7]

Whereas, preserved and skeletal anatomical specimens from as far back as the 1800s are still held by medical schools and used for educational purposes today; and [8-12]

Whereas, the need for anatomical specimens has long since outpaced supply now and even more in the distant past; and [13]

Whereas, in the 1800s the theft of the bodies of historically minoritized populations like that of indigenous, enslaved, free black, and impoverished citizens was a common practice increasing supply of anatomical specimens without attracting scrutiny from legal entities; and [14-16]

Whereas, some institutions have begun decommissioning, cremating, or returning remains of some enslaved or historically minoritized populations; and [17-19]

Whereas, other institutions have fought to hold on to remains like those of mother Bessie Wilborn, who had Paget's disease, whose skeleton still hangs at the University of Georgia against the wishes of her family; and [20-21]

Whereas, despite laws such as the Native American Graves and Repatriation Act, which “requires federal agencies and institutions that receive federal funding to return Native American "cultural items" to lineal descendants and culturally affiliated American Indian tribes, Alaska Native villages, and Native Hawaiian organizations”, museums and institutions of higher learning have not complied with these laws; and [30, 31]

Whereas, Harvard holds human remains of 19 likely enslaved individuals and thousands of Native Americans according to a recent report [29-30]; and

Whereas, the Peabody Museum at Harvard stewards a collection of hair samples, and often names, taken from Indigenous people including clippings of hair from approximately 700 Native American children attending federal Indian Boarding Schools[29]; and

Whereas, the final manifestation of medical racism is the use of patients' bodies without their consent and the repatriation of these specimens is an important step toward healing historically minoritized communities' distrust in medicine[21]; and

Whereas, today many states have presumed consent laws that still allow for bodies that haven't been claimed in as short as a few days to be donated for dissection; and [27, 28]

Whereas, the majority of unclaimed bodies are non-white persons, persons with mental health issues, or are the bodies of low-income individuals; and [26-28]

Whereas, the medical ethics community in America has expressed concern about presumed consent in the case of organ donation due to the potential for damage to the relationship of trust between clinicians caring for patients at the end of life and their families, as well as loss of autonomy especially amongst those least capable of registering objections; and [25, 26]

Whereas, AMA Code of Ethics 6.1.4. cautions against the practice of presumed consent for deceased organ donation, but the AMA has no current policy on what constitutes ethical consent processes for donation of cadavers or body parts following death for educational purposes; and

Whereas, AMA Code of Ethics 6.1.3 provides guidelines on financial incentives for cadaveric donations; however both opinions were developed in reports in 2002 and 2005 respectively, and do not consider the issues from a lens of medical racism; therefore be it

RESOLVED, that our AMA advocate for the creation of a national anatomical specimen database that includes registry demographics; and be it further

RESOLVED, that our AMA advocate for the return of human remains to living family members, or, if none exist, the burial of anatomical specimens older than 2 years where consent for permanent donation cannot be proven; and be it further

RESOLVED, that our AMA study and develop recommendations for regulations for ethical body donations including, but not limited to guidelines for informed and presumed consent; care and use of cadavers, body parts, and tissue; and be it further

RESOLVED, that our AMA amend policy 6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors should be amended by deletion to read as follows:
Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:

(a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
(b) Has been developed in consultation with the population among whom it is to be carried out.
(c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.
~~Unless there are data that suggest a positive effect on donation,~~ Nneither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented; and be it further

RESOLVED, that our AMA advocate that medical schools and teaching hospitals review their anatomical collections for remains of American Indian, Hawaiian, and Alaska Native remains

and immediately return remains and skeletal collections to tribal governments, as required by laws such as the Native American Graves and Repatriation Act; and be it further

RESOLVED, that our AMA advocate that medical schools and teaching hospitals review their anatomical collections for the remains of Black and Brown people, and other historically minoritized groups, and return remains and skeletal collections to living family members, or, if none exist, then respectful burial of anatomical specimens or remains.

Fiscal Note: Modest

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RELEVANT RFS POSITION STATEMENTS

140.102 R Redressing the Harms of Misusing Race in Medicine
That our AMA-RFS support our AMA in recognizing the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field; and that our AMA-RFS support our AMA in revising the AMA Guides to the Evaluation of Permanent Impairment, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine; and that our AMA-RFS support our AMA in promoting racism-conscious, reparative, community-engaged interventions at the health system, organized medical society, payor, local, state, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine. (Resolution 7, A-23)

350.003R Denouncing Racial Essentialism in Medicine
(1) That out AMA-RFS recognizes that race is a social construct rather than an inherent biological or genetic trait, and their false conflation can lead to inadequate examination of true underlying risk factors; (2) That our AMA-RFS recognizes that structural racism exists in the American healthcare system and that it is a systemic and public health crisis; (3) That our AMA-RFS acknowledge that there may be inherent biologic and genetic traits, distinct from race, linked to certain diseases and that these should be studied and appropriately factored into risk algorithms, screening, and treatment; (4) That out AMA-RFS encourages appropriate stakeholders to eliminate racial essentialism from clinical algorithms in an evidence-based fashion; and (5) That our AMA-RFS education curricula and board examinations. (Alternate Resolution 2, I-20)

350.005R Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic
That our AMA-RFS support the AMA in supporting training to understand the needs of housing-insecure individuals for those who encounter this vulnerable population through their professional duties; and supporting the establishment of multidisciplinary mobile homeless outreach teams trained in issues

specific to housing-insecure individuals; and reaffirming existing policies H-160.903, “Eradicating Homelessness,” and H-345.975, “Maintaining Mental Health Services by States,” and H-160.978, “The Mentally Ill Homeless”, with a title change to “Housing Insecure Individuals with Mental Illness.” (Alternate Resolution 11, I-21)

260.014R U Medical Student Training in Airway Management
That our AMA-RFS support training in techniques and decision-making in airway management of the unconscious patient for all medical students as part of their undergraduate medical education. (Substitute Resolution 1, I-97) (Reaffirmed Report C, I-07)

RELEVANT AMA POLICY

Improving Body Donation Regulation H-460.890

Our AMA recognizes the need for ethical, transparent, and consistent body and body part donation regulations.

Organ Donation and Honoring Organ Donor Wishes H-370.998

Our AMA:
(1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members
(2) when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs.

Medical Ethics and Continuing Medical Education H-300.964

The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision-making.

Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871

Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process while taking an appropriate leadership and coordinating role.

6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors

Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:

(a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.

(b) Has been developed in consultation with the population among whom it is to be carried out.

(c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.

Unless there are data that suggest a positive effect on donation, neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 2
(A-24)

Introduced by:	Connecticut Delegation - Primary Authors: Daniel Kerekes, Yale University School of Medicine; Pawan Mathew, Yale University School of Medicine
Subject:	In Support of a National Drug Checking Registry
Referred to:	Reference Committee

Whereas, recreational substance use is becoming increasingly more common, with 13.3% of respondents to a 2020 CDC survey reporting that they either started or increased substance use to help deal with stress related to COVID-19;[1] and

Whereas, recreational drugs have been found to be contaminated with adulterants at a rate up to nearly 80%;[2–4] and

Whereas, fentanyl was present in 77% of adolescent overdose deaths in 2021;[5] and

Whereas, nearly two-thirds of all overdose deaths in the United States from 2019-2020 involved synthetic opioids;[6] and

Whereas, drug checking services are point-of-care tests provided at events with high recreational drug use that can rapidly provide information to a user on the composition of the drug they intend to take;[7] and

Whereas, 94% of users of drug checking services reported they would not take a drug whose test results were unexpected;[8] and

Whereas, 32% of users of drug checking services reported that they would not take a drug if it was found to contain adulterants;[8] and

Whereas, a majority of users of drug checking services intended to share the results of the test with others;[9] and

Whereas, drug checking services can also serve as a point of contact with users of recreational drugs for other harm reduction services, and that accessibility to these resources through drug checking services is overwhelmingly supported by the target market;[10] and

Whereas, availability of drug checking services does not lead to an increase in intent to use recreational drugs;[11] and

Whereas, drug checking services are supported by over 80% of the target population;[12] and

Whereas, the Department of Health and Human Services reports that efforts to provide drug checking services have been largely effective in changing intended and actual drug use behavior;[13] and

Whereas, drug-checking services in the United States today do not have an established way to communicate trends in their results with one another; and

Whereas, a network of drug-checking services across the country could be an alternative source of information to DEA seizures to help identify early trends in supply contamination and provide education on upcoming contamination concerns to users, such as the rise of new contaminants like xylazine;[14] therefore be it

RESOLVED, that our American Medical Association (AMA) support the creation of a national drug-checking registry that would provide a mechanism whereby community-run drug-checking services may communicate their results.

Fiscal note: Minimal

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RELEVANT AMA POLICY:

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.

4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.

Pilot Implementation of Supervised Injection Facilities H-95.925
Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.

Harmful Drug Use in the United States - Strategies for Prevention H-95.978
Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.
(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.
(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol use.
(4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.
(5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.
(6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug use.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 3
(A-24)

Introduced by: Pawan Mathew, MD, Daniel Kerekes, MD

Subject: Clearing Federal Obstacles for Supervised Injection Sites

Referred to: Reference Committee

Whereas, the Anti-Drug Abuse Act of 1986 (commonly known as the “crack house statute”) outlawed the operation of houses and buildings where crack cocaine and other drugs are made or used;[1] and

Whereas, the Anti-Drug Abuse Act led to an increased disparity in prison sentencing between Black and white populations;[2-4] and

Whereas, Supervised injection facilities (SIFs), also known as overdose prevention centers, have been linked to reduction in public injection, improperly-disposed syringes and drug-related crime;[5-7] and

Whereas, SIFs have been estimated to result in significant net cost savings to communities based on reduction of transmissible diseases and wound infections[8]; and

Whereas, fentanyl overdose is the number one cause of death for Americans age 18-45, and the rate of overdose deaths continues to rise[9-10]; and

Whereas, SIFs have a proven record of preventing fatal overdoses and increasing enrollment in detoxification services[11-13]; and

Whereas, the immediate success of two SIFs in New York City has demonstrated that SIFs in the United States can be an effective tool in the battle to curb overdose deaths[14]; and

Whereas, there is demonstrated interest from a number of states to support a state-sanctioned SIF[15]; and

Whereas, the legality of SIFs is directly threatened by the Anti-Drug Abuse Act, which has been used to shut down operations of some of these programs and continues to be the major barrier to their implementation in the United States;[16-18] and

Whereas, our AMA supports the development and implementation of pilot SIFs to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use (AMA policy H-95.925); therefore be it

RESOLVED, that our American Medical Association (AMA) advocates for federal policies that empower states to determine the legality of supervised injection sites.

Fiscal Note: Moderate

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RELEVANT AMA POLICY:

H-95.925 Pilot Implementation of Supervised Injection Facilities
Our AMA supports the development and implementation of pilot **supervised injection** facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to **injection** drug use. [Res. 513, A-17; Reaffirmation A-23]

Harmful Drug Use in the United States - Strategies for Prevention H-95.978
Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.
(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.
(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol use.
(4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.

(5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.
(6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug use.
[BOT Rep. H, A-89; Reaffirmed: CSA Rep. 12, A-99; Reaffirmation I-01; Reaffirmed: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21; Reaffirmed: Res. 523, A-23]

Prevention of Drug-Related Overdose D-95.987
1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2.Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.
3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
[Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22; Modified: Res. 211, I-22; Appended: Res. 221, A-23; Reaffirmation: A-23; Modified: Res. 505, A-23]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 4
(A-24)

Introduced by: Sophia Spadafore, MD, Karen Dionesotes, MD, MPH, Dan Pfeifle, MD

Subject: Advocating for the Regulation of Pink Peppercorn as a Tree Nut

Referred to: Reference Committee

Whereas, allergy to peanuts and treenuts is the most common cause of death due to allergic reactions in the USA, with a rising prevalence;[1] and

Whereas, the prevalence of allergy to tree nuts is approximately 1.0% to 1.2% of the US population, affecting approximately 3 million people;[1,2] and

Whereas, Congress passed the Food Allergen Labeling and Consumer Protection Act of 2004 (FALCPA), identifying eight foods as major food allergens: milk, eggs, fish, Crustacean shellfish, tree nuts, peanuts, wheat, and soybeans, and sesame was recently added to the list;[3] and

Whereas, this law requires that food labels identify the food source of all major food allergens used to make the food, and the Food & Drug Administration (FDA) enforces this regulation and provides guidance on food labeling to food manufacturers;[3] and

Whereas, the "Pink Peppercorn" is often sold in peppercorn blends and has been used increasingly in food and drink products as a peppercorn, however it is actually a dried berry from the family *Schinus terebinthifolius* which is related to the cashew and pistachio family;[4] and

Whereas, studies have shown approximately 76% of people with a cashew (tree nut) allergy show cross reactivity to "pink peppercorn" and may have allergic reactions if consumed;[4,5] and

Whereas, the FDA does not currently regulate the pink peppercorn as an allergen, therefore food and drink products including it are not labeled as including tree nuts, increasing the risk of an accidental consumption by a person with a tree nut allergy;[6,7] therefore be it

RESOLVED, that our American Medical Association (AMA) will create an education campaign for the public about the pink peppercorn as a tree nut and its potential to cause severe allergic reactions; and be it further

RESOLVED, that our AMA advocates that the FDA regulate the pink peppercorn as a tree nut and require already regulated food and drink products to report inclusion of tree nuts if they include the pink peppercorn.

Fiscal Note: Modest

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RELEVANT RFS POSITION STATEMENTS:

80.005R Regulation of Herbal Preparations
That our AMA-RFS support modification of the Dietary Supplement Health and Education Act (DSHEA) to require that dietary supplements, in order to be marketed: (1) undergo Food and Drug Administration (FDA) pre-approval for evidence of safety; (2) meet criteria established by the United States Pharmacopoeia (USP) for dosage, quality, purity, packaging, and labeling; (3) meet FDA post-marketing requirements to report adverse side effects, including drug interactions and that the AMA encourage efficacy studies on dietary supplements. (Substitute Resolution 11, I-98) (Reaffirmed Report D, I-16)

RELEVANT AMA POLICY:

Preventing Allergic Reactions in Food Service Establishments D-440.932
Our American Medical Association will pursue federal legislation requiring restaurants and food establishments to: (1) include a notice in menus reminding customers to let the staff know of any food allergies; (2) educate their staff regarding common food allergens and the need to remind customers to inform wait staff of any allergies; and (3) identify menu items which contain any of the major food allergens identified by the FDA (in the Food Allergen Labeling and Consumer Protection Act of 2004) and which allergens the menu item contains.

Childhood Anaphylactic Reactions D-60.976
Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by FARE (Food Allergy Research & Education); and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis.

Food Allergic Reactions in Schools and Airplanes H-440.884
Our AMA recommends that all:
(1) schools provide increased student and teacher education on the danger of food allergies;

(2) schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use; and
(3) commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use.

Dietary Supplements and Herbal Remedies H-150.954
(1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
(2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
(3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
(4) Our AMA will work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
(5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.
(6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:
(a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;
(b) dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
(c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
(d) regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers.
(7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement.
(8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.
(9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.
10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for the product labeling to:
(a) not include structure/function claims that are not supported by evidence from robust human studies;
(b) not contain prohibited disease claims;
(c) eliminate "proprietary blends" and list and accurately quantify all ingredients contained in the product;
(d) require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and
(e) include accurate and useful disclosure of ingredient measurement.
(11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.
(12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.

(13) Our AMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 5
(A-24)

Introduced by: Daniel Kerekes, MD, Jacob Altholz, MD

Subject: Renaming the AMA-RFS Digest of Actions

Referred to: Reference Committee

Whereas, a “Digest of Actions” suggests a summary of actions executed by a body; and

Whereas, the AMA-RFS Digest of Actions lists all current positions of the AMA-RFS but does not include all actions taken by the AMA-RFS; and

Whereas, a “Position Compendium” describes a database of current positions held by the AMA-RFS; therefore be it

RESOLVED, that our AMA-RFS renames the RFS Digest of Actions to the RFS Position Compendium.

Fiscal note: Minimal

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 6
(A-24)

Introduced by: Ida Vaziri, MD

Subject: Humanitarian Efforts to Resettle Refugees

Referred to: Reference Committee

Whereas, "refugee" is defined in the Immigration and Nationality Act as an individual experiencing persecution or a well-founded fear of persecution on account of their race, religion, nationality, membership in a particular social group, or political opinion[1-3]; and

Whereas, refugees in the United States (US) undergo an extensive and complex admission process involving evaluation and referral by United Nations High Commissioner for Refugees (UNHCR, the UN's refugee agency) to the US State Department's Refugee Admissions Program (USRAP), and are a distinct population from asylum seekers or migrants crossing at the US' southern border, who follow a completely separate process[1]; and

Whereas, the US consistently admits fewer refugees than its cap, leading to 5,000 to 40,000 unallocated refugees[4]; and

Whereas, 29 million refugees are estimated in 2023, including 14 million children[5-6]; and

Whereas, over a 20-year period, refugees in the US ages 18 to 45 pay on average $21,000-$43,707 more in taxes than they receive in benefits[7-10]; and

Whereas, refugees in general contribute $21 billion in taxes annually, including to Social Security and Medicare, offsetting the costs our aging population[13]; and

Whereas, analyses from Ohio, Michigan, and Minnesota demonstrate how refugees produce billions of dollars in economic activity annually and create thousands of jobs[9,11]; and

Whereas, 77% of refugees are working age, as opposed to the 39.7% of the US-born population and male refugees participate in the labor force at higher rates than US males[7,12,14]; and

Whereas, when annual refugee admissions decreased 86% between 2016-2020, the 295,000 person gap actually harmed the US economy by nearly $10 billion annually[8]; and

Whereas, decreased resettlement caps and worsening backlogs delay family reunification and leave people displaced for decades, remaining indefinitely in refugee camps[15]; and

Whereas, forced displacement and restrictions on refugee admissions result in distinct chronic physical and mental phenomena and generational trauma[15-17]; therefore be it

RESOLVED, That our American Medical Association (AMA) support increases and oppose decreases to the annual refugee admissions cap in the United States.

Fiscal Note: Minimal

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RELEVANT AMA POLICY

D-65.984 Humanitarian and Medical Aid Support to Ukraine

Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people. [Res. 017, A-22]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 7
(A-24)

Introduced by: Samantha Beck, MD

Subject: Missing and Murdered Indigenous Persons

Referred to: Reference Committee

Whereas, there is an epidemic of violence and a rising number of cases of abduction and murder of American Indian and Alaska Native persons (AI/AN) in the United States (U.S.), with greater than 2 in 5 AI/AN women raped in their lifetime, and homicide reported in the top 10 leading causes of death according to The National Intimate Partner and Sexual Violence Survey (NIPSVS)[1,2,3]; and

Whereas, The NIPSVS reported that non-Hispanic AI/AN individuals experienced the second highest rate of homicide compared to their counterparts in all other racial and ethnic groups in 2020[3]; and

Whereas, due to factors such as racial misclassification, underreporting, and distrust between law enforcement and Indigenous communities, published statistics likely underestimate the number of sexual violence crimes and missing and murdered AI/AN persons[4]; and

Whereas, The U.S. Bureau of Indian Affairs has called for additional investigative resources to address this epidemic of violence[1]; and

Whereas, in 2019, President Trump signed Executive Order 13898, which established the two-year, multi-agency Operation Lady Justice Task Force to address the concerns of AI/AN Tribes and Villages regarding missing and murdered persons[5]; and

Whereas, in 2020, Operation Lady Justice released their first report in collaboration with tribal leaders and community members which suggested establishing local, tribal, regional, and national alert systems for AI/AN persons similar to Amber Alert[5]; and

Whereas, in 2020, Public Law No. 116-165, Savanna's Act, was signed into law to increase coordination and data-sharing among Federal, State, Tribal, and local law enforcement agencies in an attempt to improve federal prosecution rates and involvement in missing or murdered AI/AN person-cases[6]; and

Whereas, in 2021, the US Department of Interior launched the formation of the Missing & Murdered Unit (MMU) to provide additional resources and interagency cooperation with necessary stakeholders such as the Federal Bureau of Investigation on this pressing issue[7]; and

Whereas, The Urban Indian Health Institute, one of the nation's 12 Tribal Epidemiology Centers, found that the rate of missing AI/AN women in Washington State was 78.64 per 100,000, which was more than four times the rate for non-Hispanic white women in 2018[8]; and

Whereas, in 2022, Washington State established a statewide and first-in-the-nation Missing and Murdered Indigenous Women's and People's Alert System (MIPA)[9]; and

Whereas, MIPA makes AI/AN persons eligible for law enforcement assistance who do not otherwise meet strict AMBER Alert criteria and can also be used for AI/AN persons believed to be in danger and presumed to be unable to return to safety without assistance[9]; and

Whereas, in the 6 months since it was first implemented, the Washington State MIPA has been activated 33 times and 27 individuals have been located, with 4 of those cases directly attributed to MIPA[10]; and

Whereas, several states have now passed legislation to coordinate responses between tribal and non-tribal law enforcement entities and implement AI/AN-specific emergency alert systems, including Arizona, Colorado, Minnesota, Montana, North Dakota, Nebraska, New Mexico, Oregon, South Dakota, and California[8,11-12]; and

Whereas, the Urban Indian Health Institute has also challenged lawmakers and policymakers to consider a number of factors in their responses to this crisis, including law enforcement stigma towards substance use in AI/AN communities, non-reporting of LGBTQ2S+ identification for missing and murdered AI/AN persons, lack of coordination between tribal, state, and federal law enforcement, and inadequate protocols regarding AI/AN persons living away from their tribal lands[9]; therefore be it

RESOLVED, that our AMA-RFS supports emergency alert systems for American Indian and Alaska Native tribal members reported missing on reservations and in urban areas.

Fiscal Note: Minimal

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RELEVANT AMA POLICY:

Addressing Sexual Violence and Improving American Indian and Alaska Native Women's Health Outcomes D-350.985

1. Our AMA advocates for mitigation of the critical issues of American Indian/Alaska Native women's health that place Native women at increased risk for sexual violence, and encourages allocation of sufficient resources to the clinics serving this population to facilitate health care delivery commensurate with the current epidemic of violence against Native women.

2. Our AMA will collaborate with the Indian Health Service, Centers for Disease Control and Prevention (CDC), Tribal authorities, community organizations, and other interested stakeholders to develop programs to educate physicians and other health care professionals about the legal and cultural contexts of their American Indian and Alaska Native female patients as well as the current epidemic of violence against Native women and the pursuant medical needs of this population.
3. Our AMA will collaborate with the Indian Health Service, CDC, Tribal authorities, and community organizations to obtain or develop appropriate American Indian and Alaska Native women's health materials for distribution to patients in the spirit of self-determination to improve responses to sexual violence and overall health outcomes. [Res. 208, I-15]

Preventing Anti-Transgender Violence H-65.957
Our AMA will: (1) partner with other medical organizations and stakeholders to immediately increase efforts to educate the general public, legislators, and members of law enforcement using verified data related to the hate crimes against transgender individuals highlighting the disproportionate number of Black transgender women who have succumbed to violent deaths: (2) advocate for federal, state, and local law enforcement agencies to consistently collect and report data on hate crimes, including victim demographics, to the FBI; for the federal government to provide incentives for such reporting; and for demographic data on an individual's birth sex and gender identity be incorporated into the National Crime Victimization Survey and the National Violent Death Reporting System, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (3) advocate for a central law enforcement database to collect data about reported hate crimes that correctly identifies an individual's birth sex and gender identity, in order to quickly identify positive and negative trends so resources may be appropriately disseminated; (4) advocate for stronger law enforcement policies regarding interactions with transgender individuals to prevent bias and mistreatment and increase community trust; and (5) advocate for local, state, and federal efforts that will increase access to mental health treatment and that will develop models designed to address the health disparities that LGBTQ individuals experience.
Res. 008, A-19

Missing Children Identification H-60.996
The AMA supports (1) development of a means of identifying children; and (2) education of the public and parents on the fingerprinting and documentation of characteristic identifying marks as a matter of record, should it be necessary to assist officials in locating a missing child. [Res. 98, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14]

Fund for Public Health Emergency Response H-440.825
Our AMA supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts. [Res. 420, A-16]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 8
(A-24)

Introduced by: Samantha Beck, MD

Subject: Public Service Loan Forgiveness Reform

Referred to: Reference Committee

Whereas, there is a physician shortage across all specialties, locations, and practice types in the United States[1]; and

Whereas, the federal government is responsible for direct healthcare services through the Veteran's Health Administration (VHA) and Indian Health Service (IHS); and

Whereas, the VHA and IHS both experience chronic, nationwide physician shortages (12.9% at VHA as of 2022[2], 25% at IHS as of 2018[3]), paralleling the nation's physician shortage; and

Whereas, the VHA loan repayment program offers up to $200,000 in relief to physicians over five years, with no service commitment, while the IHS loan repayment program offers up to $50,000 in relief to physicians, with a two-year service commitment4-[5]; and

Whereas, the VHA has bolstered physician retention and reduced physician burnout by offering competitive financial relief to physicians and making improvements in workload, organizational satisfaction, and psychological safety[6-7]; and

Whereas, the VHA compensates physicians using Title 38 pay scales, which provides special authority to recruit and retain employees in certain health care occupations, and also allows the agency to be competitive with other healthcare facilities in the area[8-9]; and

Whereas, the IHS compensates physicians using Title 5 pay scales, which are generally less than Title 38 pay scales[10-11]; and

Whereas, the IHS compensates non-physician members of the health care team using Title 38 pay scales, undervaluing the importance of physician leadership in health care[10-11]; and

Whereas, the Partnership for Public Service and Boston Consulting Group (PPS-BCG) reported that the IHS ranked in the bottom-quartile of agencies within the U.S. Department of Health and Human Services for employee engagement and satisfaction (332 of 432) in 2022[12]; and

Whereas, the PPS-BCG reported that nearly half of IHS physicians and other employees were not satisfied with their pay and nearly a third were not satisfied with their work-life balance in 2022[12]; and

Whereas, the AMA recommends that compensation for IHS physicians be increased to a level competitive with other federal agencies and non-governmental service (H-350.977); and

Whereas, physicians employed by the federal government may be eligible for the Public Service Loan Forgiveness Program, which forgives qualifying federal loans after a standard ten-year repayment plan[13]; and

Whereas, loan repayment can address physician retention and decrease physician burnout in facilities that may not provide competitive pay or are in geographically remote locations[14-16]; and

Whereas, the AMA has stated that reducing physician burnout should be an urgent priority[17]; and

Whereas, the AMA already supports immediate changes in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veteran's Health Administration facility (D-510.990) due to the VA physician shortage; therefore be it

RESOLVED, that our AMA-RFS support efforts to improve physician payment and student loan reimbursement within the Indian Health Service.

Fiscal Note: Minimal

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RELEVANT AMA POLICY

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.
(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.
(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.
(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.
(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.
(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.
(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

Fixing the VA Physician Shortage with Physicians D-510.990
1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.
2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.
3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.
4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.
5. Our AMA supports postgraduate medical education service obligations through programs where the expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee.
6. Our AMA opposes the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training.

Physician Burnout D-405.972
Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925
The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:
1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the “20/220 pathway,” and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were

chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer’s PSLF program qualifying status; (f) Advocate that the profit status of a physician’s training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged

for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.
24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.
25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including
educational and cost of attendance debt.
26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

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.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 9
(A-24)

Introduced by: Clarissa P. Diniz, MD, Savannah P. Ayala, MD

Subject: Bilateral Tubal Ligation (BTL) Federal Policy Modification Recommendation

Referred to: Reference Committee

Whereas, female sterilization via occlusion of the fallopian tubes is the most common form of contraception in the United States;[1] and

Whereas, postpartum sterilization accounts for 50-70% of all sterilizations;[2] and

Whereas, all patients with Medicaid insurance undergoing surgical sterilization in the United States are required to sign a national informed consent form at least 30 days, but not more than 180 days, prior to their surgery in order for hospitals to receive sterilization payment from publicly funded insurances; and

Whereas, current regulations on government-funded sterilization arose in 1978 in an attempt to rectify a longstanding history of coercive sterilization of marginalized groups,[3] however, it has become a common barrier to sterilization and its mandatory 30-day waiting period represent unreasonable and unnecessary burden to care;[2,4] and

Whereas, approximately 30-50% of desired postpartum sterilizations are not performed,[2] of those, nearly 50% of these patients present pregnant within one year;[5] and

Whereas, the American College of Obstetrics and Gynecology (ACOG) recommends that the "sterilization policies and forms should be modified in order to create fair and equitable access for individuals regardless of insurance status or type;"[6] and

Whereas, ACOG recommends that consideration of "redefining the validity time frame (ie, considering the form valid 24 hours after signature and extending validity to 1 year from signature date);"[6] and

Whereas, our AMA has policy which emphasizes the importance of broad and equitable access to all aspects of reproductive health services, including abortion and contraception (AMA policy D-5.999); therefore be it

RESOLVED, that our AMA-RFS support modifying the Bilateral Tubal Ligation (BTL) Federal Medicaid Form from the 30 days mandatory waiting period to 24 hours, and the 180 days consent form expiration to 365 days.

Fiscal Note: Minimal

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RELEVANT AMA POLICY:

Preserving Access to Reproductive Health Services D-5.999
Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, fertility preservation, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will advocate for legal protections for medical students and physicians who cross state lines to receive education in or deliver reproductive health services, including contraception and abortion.
[Res. 028, A-22; Reaffirmed: Res. 224, I-22; Modified: BOT Rep. 4, I-22; Appended: Res. 317, I-22; Reaffirmation: A-23; Appended: Res. 711, A-23]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 10
(A-24)

Introduced by: Christina Wang, MD, Morgan Leighton, MD, Michelle Leach, MD, Dayna Isaacs, MD

Subject: Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates

Referred to: Reference Committee

Whereas, supporting trainees with adequate parental leave is associated with improved resident wellness and productivity, as well as long-term maternal and child health outcomes;[1-3] and

Whereas, as of October 2020, all federal employees including members of the military are eligible for 12 weeks of paid parental leave for the birth or adoption of a child;[4] and

Whereas, both the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) recommend that up to 12 weeks of paid parental leave should be available during residency training;[8] and

Whereas, a study of top-ranked hospitals and cancer centers found that the mean paid maternity and parental leave is 7.8 and 3.6 weeks, respectively, well below the 12-week paid family leave recommendation of the American Academy of Pediatrics and the mean of 18.6 weeks afforded by other Organization for Economic Co-operation and Development countries;[5] and

Whereas, the Family and Medical Leave Act of 1993 gives “eligible” employees of large employers and all government agencies regardless of size to take unpaid leave if it has been earned (defined as after 12 months of work) for a period of up to 12 weeks in any 12 month period;[6] and

Whereas, there are state-based parental leave laws that also require employees to have worked at least 12 months, which poses a burden for new graduates from residency and fellowship;[7] and

Whereas, in survey responses many residents do not feel supported in taking parental leave due to perceived or actual lack of support from faculty / peers, strain on residency program, lack of flexibility of programs;[8] and

Whereas, in one survey, ⅔ of medical trainees who were parents felt that child care contributed to their burnout especially when compounded by short parental leave and the difficulties of a relatively low resident salary;[9] and

Whereas, in one survey of trainees in an institution and state offering only unpaid parental leave, the leading factor influencing length of parental leave time was financial;[10] and

Whereas in one survey, nearly 40% of surgical trainees reported considering leaving residency during or after pregnancy for reasons including dissatisfaction with leave options;[11] and

Whereas, many women physicians delay childbearing until after training which often overlaps with periods of peak fertility such that approximately ¼ of women physicians report infertility, up to double the rate of the general US population;[12-14] and

Whereas, even if residencies and fellowships are supporting paid leave, there is limited flexibility to support residents finishing residency on time including limited board licensing exam dates; therefore be it

RESOLVED, that our American Medical Association (AMA) supports paid parental leave benefits for physicians regardless of length of employment.

Fiscal Note: Minimal

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RELEVANT RFS POSITION STATEMENTS:

291.010R Impact of Specialty Board Mandated Residency Completion Dates on Parental Leave During Residency
In order to accommodate leave protected by the federal Family and Medical Leave Act (FMLA), the AMA encourage all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year. (Resolution 2, A-09)

294.024R Pregnancy and Parental Leave for Trainees
1) That our AMA-RFS study legal and policy mechanisms to promote and enforce reasonable workplace accommodations for residents and fellows during pregnancy; and 2) that our AMA-RFS study policy mechanisms to promote workplace accommodations such as the option to defer night shift work in the 1st or 3rd trimesters, less physically demanding rotations while in the 3rd trimester of pregnancy, and time off

for scheduled medical appointments without having to use vacation time, elective blocks, or sick leave, which also do not create an undue burden on other trainees; and 3) That our AMA-RFS supports the provision of up to 12 weeks of fully paid parental leave for all resident and fellow trainees, that is separate from elective/research blocks, vacation or sick time; and 4) that our AMA RFS supports the development of flexible policies for all trainees who take parental leave and whose residency programs are able to certify that they meet appropriate competencies for program completion to graduate and maintain board-eligibility in their expected time frame. (Alternate Resolution 7, I-23)

RELEVANT AMA POLICY:

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students

with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.

15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.

17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.

18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 11
(A-24)

Introduced by: Sally Midani, MD, Hussein Antar, MD, MPH, Nikita Sood, MD, Sohayla Rostami, DO

Subject: Opposition to Collective Punishment

Referred to: Reference Committee

Whereas, a United Nations (UN) report found that nearly 828 million individuals were impacted by hunger and food insecurity in 2021[1]; and

Whereas, the Integrated Food Security Phase Classification (IPC) offers the most widely accepted definition of famine as "at least 20% of households facing an extreme lack of food, at least 30% of children suffering from acute malnutrition, and two people for every 10,000 dying each day due to outright starvation or to the interaction of malnutrition and disease"[2]; and

Whereas, a UN report of the Special Rapporteur on the right to food published in December 2022 identified conflict and violence as the primary causes of hunger, malnutrition, and famine[3]; and

Whereas, the UN report identifies starvation as intentionally utilizing famine as a method of warfare and may trigger laws of war as it serves as an attempt to "annihilate or weaken a population by depriving people of food, water and other essentials for survival, including the means to produce and procure food"[3]; and

Whereas, in warfare, far more deaths occur as a result of humanitarian crises created by a conflict (e.g. sieges, starvation) than from the hostilities themselves[4]; and

Whereas, article 4 in Section I of the Geneva Conventions recognizes sick persons, wounded persons, and civilians as protected persons in the context of conflict and warfare[5]; and

Whereas, article 33 in Section IV of the Geneva Conventions prohibits the punishment of a protected person for an offense they have not personally committed, further prohibiting collective penalties, measures of intimidation, pillage, and reprisals against protected persons and their property[6]; and

Whereas, a 2018 UN Security Council resolution reaffirmed the "obligation of all parties to an armed conflict to comply with international humanitarian law", recognized the unique relationship between hunger and armed conflict while acknowledging the complexity of hunger in holistic and systemic terms [7]; and

Whereas, the IPC Famine Review Committee (FRC) released a report on the Gaza Strip in March 2024 which found that 95% of the analyzed population is at emergency-level food insecurity or higher and that famine is imminent[8]; and

Whereas, the U.S. Agency for International Development (USAID) declared an ongoing famine in parts of Gaza during a congressional hearing in April 2024[9]; and

Whereas, the IPC FRC report identified the destruction of food, health, and water systems as well as restricted humanitarian access as key drivers of the current state of food insecurity in Gaza, which has largely been a result of the ongoing crisis between Palestine and Israel[8]; and

Whereas, food entering Gaza meets only approximately 7% of daily caloric needs of the civilians with water production at 5% of normal levels[10]; and,

Whereas, on March 28th, 2024, The World Court of the International Court of Justice unanimously ordered Israel to take all necessary and effective action to ensure basic food supplies to the enclave's Palestinian population and halt spreading famine[11]; and

Whereas, nearly $806 billion of United States (US) taxpayer money has been distributed to the National Defense budget in 2023[12]; and

Whereas, following the events of October 7th, the US government has approved an additional $2 billion in addition to the standing $3.8 billion of aid to Israel[13,14]; and

Whereas, in November of 2023 the Biden administration requested an additional $14 billion in aid towards Israel[15]; and

Whereas, the Code of Medical Ethics of the American Medical Association reaffirmed in 2023 in "A Declaration of Professional Responsibility H-140.900" specifically adopted declaration number two, "Refrain from supporting or committing crimes against humanity and condemn any such acts"; and

Whereas, AMA policy D-65.984 "Humanitarian and Medical Aid Support to Ukraine" specifies that our AMA will advocate for "continuous support of organizations providing humanitarian missions and medical care"; and

Whereas, international relief agencies such as the United Nations Reliefs and Works Agency for Palestinian Refugees in the Near East (UNRWA) and the United Nations High Commissioner for Refugees (UNHCR) provide on the ground support to refugees displaced by actions of war[16,17]; therefore be it

RESOLVED, that our American Medical Association (AMA) oppose collective punishment tactics—including restrictions on access to food, water, electricity, and healthcare—as tools of war; and be it further

RESOLVED, that our AMA oppose the use of United States funding to any entities that (1) do not uphold international law; or (2) commit or condone war crimes; and be it further

RESOLVED, that our AMA condemn the ongoing use of United States resources to enforce collective punishment on civilians in Gaza and the surrounding regions; and be it further

RESOLVED, that our AMA advocate for federal funding and support for the United Nations High Commissioner for Refugees (UNHCR), the United Nations Reliefs and Works Agency for Palestinian Refugees in the Near East (UNRWA), and other national and international agencies and organizations that provide support for refugees; and be it further

RESOLVED, that this resolution be immediately forwarded to the AMA House of Delegates at the 2024 Annual Meeting.

Fiscal note: Moderate

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RELEVANT AMA POLICY:

A Declaration of Professional Responsibility H-140.900

Our AMA adopts the Declaration of Professional Responsibility

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE's SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

(1) Respect human life and the dignity of every individual.

(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.
(3) Treat the sick and injured with competence and compassion and without prejudice.
(4) Apply our knowledge and skills when needed, though doing so may put us at risk.
(5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
(6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
(7) Educate the public and polity about present and future threats to the health of humanity.
(8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
(9) Teach and mentor those who follow us for they are the future of our caring profession.
We make these promises solemnly, freely, and upon our personal and professional honor.

Humanitarian and Medical Aid Support to Ukraine D-65.984
Our AMA will advocate for: (1) continuous support of organizations providing humanitarian missions and medical care to Ukrainian refugees in Ukraine, at the Polish-Ukrainian border, in nearby countries, and/or in the US; (2) an early implementation of mental health measures, including suicide prevention efforts, and address war-related trauma and post-traumatic stress disorder when dealing with Ukrainian refugees with special attention to vulnerable populations including but not limited to young children, mothers, pregnant women, and the elderly; and (3) educational measures to enhance the understanding of war-related trauma in war survivors and promote broad protective factors (e.g., financial, employment, housing, and food stability) that can improve adjustment and outcomes for war-affected people, particularly when applied to vulnerable categories of people.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 12
(A-24)

Introduced by: Dayna Isaacs, MD, Karthik Sarma, MD, Jacob Altholz, MD, Christina Wang, MD, Elisa Quince, MD

Subject: Transparency and Access to Medical Training Program Unionization Status, Including Creation of a FREIDA Unionization Filter

Referred to: Reference Committee

Whereas, housestaff are represented predominantly by the Committee of Interns and Residents (CIR),[1] with other organizations including the Union of American Physicians and Dentists (UAPD), the American Federation of State, County & Municipal Employees (AFSCME), and the American Federation of Teachers (AFT); and

Whereas, given limitations of the residency and fellowship Match that inhibit free market competition for applicants, including ability to negotiate a contract, unionization is the sole mechanism for negotiation via collective bargaining[2,3]; and

Whereas, housestaff are vulnerable health care workers who are unable to negotiate a contract prior to employment, easily transfer jobs, or leave their job without sacrificing their career prospects; and

Whereas, current AMA policy supports the unionization of physicians (Policy H-385.946, H-385.976) and supports the study of alternative options to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants (Policy D-310.944); and

Whereas, The AMA has promoted unionization for housestaff through its media outlets[6];and

Whereas, There is no existing AMA policy supporting the dissemination of existing unionized hospitals for trainees to make more informed decisions about their workplace environment during the Match process; and

Whereas, FREIDA™ is the AMA's residency/fellowship database which allows members to browse over 13,000 ACGME-accredited programs, with filters for specialty, location, application type, visas accepted, childcare options, salary, and percentage U.S. MD/DO/IMG; and

Whereas, FREIDA™ does not have a filter for program unionization; therefore be it

RESOLVED, that our American Medical Association (AMA) supports transparency and access to information about medical training program unionization status; and be it further

RESOLVED, that our AMA creates and maintains an up-to-date unionization filter on FREIDA™ for trainees to make informed decisions during the Match.

Fiscal Note: Moderate

REFERENCES:

1. Committee of Interns and Residents: The National Voice of Residents. Committee of Interns and Residents/SEIU Healthcare https://www.cirseiu.org/
2. Boston Medical Center Corp., 330 N.L.R.B. 152 (N.L.R.B-BD 1999)
3. Jung v. Association of American Medical Colleges, 339 F. Supp. 2d 26 (D.D.C. 2004)
4. What I Wish I Knew in Residency About Collective Bargaining. The American Medical Association. March 21, 2024. https://www.ama-assn.org/medical-residents/residency-life/what-i-wish-i-knew-residency-about-collective-bargaining

RELEVANT RFS POSITION STATEMENTS:

Investigation into Residents, Fellows, and Physician Unions 170.011R
That our AMA-RFS support the study of the feasibility of a national house-staff union to represent all interns, residents and fellows. (Resolution 14, A-18) (Reaffirmed Resolution 4, A23)

Resident and Fellow Bill of Rights 291.009R
That our AMA-RFS support a Residents' and Fellows' Bill of Rights that will serve as a testament to the organization's support for and commitment to the education and training of competent, conscientious residents and fellows by illuminating their rights and advocating for provisions that it believes all residents should be afforded, and that have not yet been designated as rights, and that residents and fellows have a right to:
E. Adequate compensation and benefits that provide for resident well-being and health. (1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal; and c. Recognition as full-time workers and a right to unionize, granting residents and fellows the ability to advocate collectively to employers and lawmakers on behalf of patients and themselves as workers, not only as learners.

Collective Negotiations by Residents 293.006R
That our AMA ask its representatives to the ACGME to continue their diligence in supporting inclusion of the following AMA proposed amended language into Section 1,B,3,e(1) of ACGME's Institutional Requirements: Section 1,B,3,e(1) Provision of an organization system for communication and resolution of resident concerns on all issues pertaining to resident educational 54 AMA-RFS Digest of Actions programs, patient care and resident well being. Institutions must allow resident physicians the ability to form a resident organization and use it or other forums to facilitate regular assessment of resident concerns; (2) that the AMA approve a nationwide program offering supporting materials and telephone and on-site assistance to groups of residents seeking to form independent housestaff organizations advocating no actions resulting in withholding care; and (3) that the AMA study the potential affects on future resident demand for housestaff associations or unionizations should the NLRB rule that all residents are subject to legal protections under the NLRA and make recommendations as to ways in which the AMA can appropriately address those demands. (Report F, A-98)

Housestaff Organizations 293.004R
That our AMA (1) continue to support the development of independent housestaff associations as one option for resident and fellow physicians who wish to organize and advocate to improve or affect the quality of patient care; (2) be prepared to implement a national labor organization specifically for all eligible resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize a bargaining unit under the National Labor Relations Act; and (3) continue to vigorously support antitrust relief that would permit collective bargaining between groups of self-employed physicians and health plans/insurers/hospitals, and be prepared to implement a national labor organization for these physicians should antitrust relief occur. (Report F, A-99) (Reaffirmed Report C, I-09)

RELEVANT AMA POLICY:

Investigation into Residents, Fellows and Physician Unions D-383.977
Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment.

Resident Physicians, Unions and Organized Labor H-383.998
Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.

Political Action by Physicians 1.2.10
Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care. Physicians who participate in advocacy activities should: (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised. (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice. (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients. (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

Physician Collective Bargaining H-385.976
Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians. (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature. (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively. (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients. (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

Collective Bargaining for Physicians H-385.946
The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.

Investigation into Residents, Fellows and Physician Unions D-383.977
Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment.

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988
Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

Study of the Current Match Process and Alternatives D-310.944
Our American Medical Association will study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 13
(A-24)

Introduced by: Pareena Kaur, MD, Rachel Abbott, MD, Mallorie Nguyen, MD, Akshara Malla, MD, Dayna Isaacs, MD

Subject: Soil Health

Referred to: Reference Committee

Whereas, soil is a "living and life-giving natural resource" containing a diverse microbiome which serves as the foundation of a vital symbiotic ecosystem[1]; and

Whereas, soil health encompasses the capacity by which the soil can carry out five vital functions: regulate water, sustain plant and animal life, filter and buffer potential pollutants, cycle nutrients, and provide physical stability and support[1]; and

Whereas, healthy soils provide resiliency to counteract the impacts of climate change, examples of which include reduced flooding, reduced local extreme heat (heat island effect), improved cooling as well as improved physical and mental health benefits of greenspace, reduced local air pollution, and carbon sequestration to help achieve net zero emissions[2]; and

Whereas, existing healthy soil initiatives such as California's Healthy Soils Initiative encourage partnerships between the local governments, farmers, and stakeholders to prioritize and invest in healthy agricultural soils[3]; and

Whereas, an ethical dilemma underlies current food production and distribution practices which are neither in support or promotion of planetary or human health[4]; and

Whereas, a food forest mimics how plants grow naturally on multiple layers within a forest, "consist[ing] of a canopy with tall fruit and nut trees, shrubs and bushes which bear fruit, a layer including herbs and vegetables, and ground-hugging plants, vines and roots"[5]; and

Whereas, a food forest is a radical concept for redefining how food is grown to align with goals of ecological sustainability which can "boost biodiversity, contribute to food security, and help build more sustainable and resilient communities"[5,6]; and

Whereas, Boston Medical Center created a 2658 sq ft modular rooftop farm, which produces as much as 3 tons of produce every year, enough to serve 1800 meals daily, as well as support an on-site teaching kitchen and donate free vegetables to patients with low incomes in the community[7]; and

Whereas, hospitals and medical centers have a moral public health responsibility to patients and the planet to promote and offer healthy food options through their adoption of healthy soil initiatives, food forests, and partnerships with local agencies[7]; therefore be it

RESOLVED, that our AMA recognizes the vital role healthy soils play in mitigating climate change impacts and in improving the health of individuals, communities, and the planet; and be it further

RESOLVED, that our AMA supports soil health initiatives, including, but not limited to, the development of sustainable food forests; and be it further

RESOLVED, that our AMA urges healthcare organizations to act as environmental stewards when and where possible via healthy soil practices and development of sustainable food forests.

Fiscal Note:

REFERENCES:

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6. Tallarico G. Food Forests FAQ. World Permaculture Association. Published October 18, 2019. https://worldpermacultureassociation.com/food-forests-faq/
7. How Should Food Offered by Health Care Organizations Meet Individual, Community, and Ecological Needs? AMA J Ethics. 2023; 25(4): E256-263. https://journalofethics.ama-assn.rorg/sites/joedb/files/2023-03/cscm3-2304_0.pdf

RELEVANT RFS POSITION STATEMENTS:

Supporting the Use of Renewable Energy in Healthcare 230.012R
That our AMA-RFS advocate for the importance of healthcare systems' timely transition to renewable energy, including wind, solar, geothermal technology, biomass, and hydropower energy; and That our AMA-RFS support implementations of policies and incentives that promote the healthcare sector's transition to renewable energy. (Resolution 4, I22)

RELEVANT AMA POLICY:

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.

Sustainable Food D-150.978
Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) supports sustained funding for evidence-based policies and programs to eliminate disparities in healthy food access, particularly for populations vulnerable to food insecurity, through measures such as tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.

Declaring Climate Change a Public Health Crisis D-135.966
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. 3. Our AMA will consider signing on to the Department of Health and Human

Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050. 5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

Global Climate Change and Human Health H-135.938
Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change.
2. Supports educating the medical community on the 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 the physical and mental health effects of climate change and 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 adaptation interventions are equitable and prioritize the needs of the populations most at risk.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

Declaring Climate Change a Public Health Crisis D-135.966
1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. 3. Our AMA will consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050. 5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

Evaluating Green Space Initiatives H-470.953
Our AMA supports appropriate stakeholders in conducting studies to evaluate different green space initiatives that could be implemented in communities to improve patients' health and eliminate health disparities.

Support Reduction of Carbon Dioxide Emissions D-135.972
Our AMA will (1) inform the President of the United States, the Administrator of the Environmental Protection Agency (EPA), and Congress that our American Medical Association supports the Administration's efforts to limit carbon dioxide emissions from power plants to protect public health; and

(2) working with state medical societies, encourage state governors to support and comply with EPA regulations designed to limit carbon dioxide emissions from coal fired power plants.

Support of Clean Air and Reduction in Power Plant Emissions H-135.949
1. Our AMA supports (a) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (b) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels. 2. Our AMA will: (a) support the Environmental Protection Agency’s proposal, under the Clean Air Act, to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks; and (b) urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public’s health are enforceable.

EPA and Green House Gas Regulation H-135.934
1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States. 2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.

Federal Clean Air Legislation H-135.984
1. Our AMA urges the enactment of comprehensive clear ambient air legislation which will lessen risks to human health. 2. Our AMA will: (a) oppose legislative or regulatory changes that would allow power plants to avoid complying with new source review requirements to install air pollution control equipment when annual pollution emissions increase; and (b) work with other organizations to promote a public relations campaign, strongly expressing our opposition to EPA’s Affordable Clean Energy rule and its proposed amendments of the New Source Review requirements under the Clean Air Act.

AMA Public Health Strategy D-440.912
1. Our AMA will distribute evidence-based information on the relationship between climate change and human health through existing platforms and communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 14
(A-24)

Introduced by: Karen Dionesotes, MD, MPH, Whitney Sambhariya, MD, PhD, Max Galvan, MD, Ariel Carpenter, MD

Subject: Updated Recommendations for Child Safety Seats

Referred to: Reference Committee

Whereas, motor vehicle crashes are the leading cause of death in children aged 5-14. Each year, more than 2,000 children and adolescents under the age of 21 years die in motor vehicle crashes[1-3]; and

Whereas, in 2020 63,000+ children less than 13 years of age were injured in a motor vehicle crash with nearly 23,000 (36%) of these children not being buckled into the vehicle[4]; and

Whereas, American Indian and Alaska Native children and Black children are more likely to die in a motor vehicle crash than White children, and children in rural areas are more likely to die in a motor vehicle crash compared to urban areas[5,6]; and

Whereas, over the past decades, car seat technology has steadily improved in safety and ease-of-use features and provided higher weight and length limits at each stage; and
Whereas, Multiple reasons exist for not using a car seat, one of which includes lack of access to affordable car seats[4]; and

Whereas, being unrestrained in a vehicle increases the risk of being killed in a crash. A 2021 National Highway Traffic Safety Administration Report using fatal crash data found that 30% of 0-3-year-olds and 36% of 8-12–year-olds killed in motor vehicle crashes were not buckled up[7]; and

Whereas, car safety seats and booster seats have been shown to be superior to a seatbelt alone in preventing death and serious injury for young children by reducing the risk of injury by up to 71-82% for car seats and 45% for booster seats[4]; and

Whereas, the choice of car seat, booster seat, or seat belt should be determined based on age and size of the child, which may not always be common knowledge to parents; and

Whereas, the American Academy of Pediatrics (AAP) and Center for Disease Control and Prevention (CDC) offer guidance on motor vehicle transportation of children, however, AMA policies have not been updated with newer recommendations surrounding the specific use of child safety seats[2,4]; therefore be it

RESOLVED, that our American Medical Association (AMA) Policy 15.950, “Child Safety Seats - Public Education and Awareness” be amended by addition and deletion to read as follows:

> Our AMA supports efforts to require child safety seat manufacturers to include information about the importance of rear-facing safety seats, forward facing safety seats, and booster seats until children ~~are two years of age or until they~~ reach the maximum

age, height or weight specifications of their car seat~~, at which time they should be placed in a forward-facing child safety system with a harness as recommended by the American Academy of Pediatrics~~ using: (1) rear-facing car safety seats with a harness in the back seat for as long as possible; (2) forward-facing car safety seats from the time they outgrow rear-facing seats for most children through at least 5 years of age; (3) belt-positioning booster seats from the time they outgrow forward-facing car seats until a seat belt fits properly with the lap belt across the upper thighs and the shoulder belt across the center of the shoulder and chest (4) lap and shoulder seat belts for all who have outgrown booster seats and (5) that all children regardless of car seat, booster seat, or seat belt use remain properly buckled in the back seat until age 13

Fiscal Note: Minimal

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RELEVANT RFS POSITION STATEMENTS:

10.002R Amending Child Restraints Laws
That our AMA-RFS support federal legislation that increases law enforcement standards for child safety seat use in the U.S. and support state and federal legislation that updates child car seat violations from a secondary to a primary law. (Resolution 4, A-07)

RELEVANT AMA POLICY:

Child Safety Seats - Public Education and Awareness H-15.950
Our AMA supports efforts to require child safety seat manufacturers to include information about the importance of rear-facing safety seats until children are two years of age or until they reach the maximum height or weight specifications of their car seat, at which time they should be placed in a forward-facing child safety system with a harness as recommended by the American Academy of Pediatrics. [Res. 922, I-14]

Amending Child Restraint Laws H-440.870
Our AMA supports: (1) federal legislation that increases law enforcement standards for child safety seat use in the United States; and (2) state and federal legislation that updates child car seat violation codes from a secondary to primary law. [Res. 913, I-07; Reaffirmed: BOT Rep. 22, A-17]

Modification of Three-Point Shoulder Harness Seat Belt to Enable Use by Small Children H-15.988
The AMA (1) recognizes the value of using appropriately designed three-point safety belt restraints to reduce auto-related injuries and fatalities; (2) supports auto industry modifications in restraints for safe use by children and small adults; and (3) supports the development of standards required for such modifications by appropriate authorities. [Sub. Res. 33, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 15
(A-24)

Introduced by: Karen Dionesotes, MD, MPH, Pauline Huynh, MD, Sophia Spadafore, MD

Subject: No Trainee Left Behind

Referred to: Reference Committee

Whereas, Graduate Medical Education (GME) is funded through both private and public sources[1-4]; and

Whereas, the largest source of funding for GME, specifically for residency positions, is through Medicare, both through direct (DGME) and indirect (IME) payments[1-4]; and

Whereas, additional federal funding comes from HRSA grants, the VA, and Department of Defense[1-4]; and

Whereas, Medicare payments cover residents in approved programs, accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), the American Dental Association (ADA), or the American Podiatric Medical Association (APMA)[3,5]; and

Whereas, Medicare will pay 1.0 FTE for each resident within their initial residency period, or the minimum number of years required for a resident to become board eligible in the specialty in which the resident first begins training, as determined by the ACGME[3,6]; and

Whereas, Medicare GME may have indirect effects on fellowship funding through various mechanisms such as hospital budget allocation, and contributing to infrastructure, resources and workforce development initiatives that can then support fellowship training[3,4]; and

Whereas, fellowships rely on private foundations, direct funding from the institution, government grants, endowments and donations, and/or other funding sources (often a combination of funding sources) to fund the fellowship[3,4]; and

Whereas, this difference in funding structure or pool can allow institutions to provide inferior benefits and salaries for fellows as compared to residents; and

Whereas, one can complete residency at an institution and have fringe benefits such as having subsidized parking, a 403b match, and/or gym membership, only to lose those benefits once they transition to fellowship at the same institution; and

Whereas, fellows often are older, carry more clinical responsibility, and may be more likely to have dependents compared to residents, and despite this, may receive fewer/inferior benefits compared to residents at the same institution; and

Whereas, all resident and fellow trainees deserve to be eligible for the same benefits, no matter what the funding source is for their program; therefore be it

RESOLVED, that our AMA-RFS amend policy 293.011R by addition and deletion to read as follows:

293.011R Benefit Packages for Resident and Fellow Physicians
That our AMA-RFS support that: (1) all institutions be required to provide their fellow and resident physicians with disability insurance, life insurance, HIV indemnity, malpractice insurance including tail coverage, retirement benefits, health, sick leave and wages commensurate with their education and experience; and (2) if a given benefit or salary is provided to some residents or fellows within a given program at the same postgraduate level, then that benefit must be provided to all residents and fellows, but this provision should not be used to eliminate the benefit in question.; and (3) all institutions provide parity in salary and benefits between residents and fellows; and be it further

RESOLVED, that our AMA-RFS amend 291.009R Resident and Fellow Bill of Rights by addition to read as follows:

E. Adequate compensation and benefits that provide for resident and fellow well-being and health.
(1) With regard to contracts, residents and fellows should receive:
a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and
b. At least four months advance notice of contract non-renewal and the reason for non-renewal; and
c. Recognition as full-time workers and a right to unionize, granting residents and fellows the ability to advocate collectively to employers and lawmakers on behalf of patients and themselves as workers, not only as learners.
(2) With regard to compensation, residents and fellows should receive:
a. Compensation for time at orientation; and
b. Salaries commensurate with their level of training and experience. Compensation should enable trainees to support their families and pay educational debts, reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living and differences based on geographical location.
(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive:
a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents, fellows, and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program;
b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues;
c. Confidential access to mental health and substance abuse services;
d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks without pressure to leave it unused or penalization for its use;
e. Leave in compliance with the Family and Medical Leave Act; and

f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided; and
g. That there is parity between residents' and fellows' benefits within the same institution.; and be it further

RESOLVED, That our AMA-RFS update language in its Digest of Actions to ensure that position statements are reflected to include fellows in the positions already in the Digest for resident protections, benefits, salary, when appropriate; and be it further

RESOLVED, That our American Medical Association (AMA) amend Residents and Fellows' Bill of Rights H-310.912 by addition to read as follows:

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services, and will encourage institutions to provide parity in salary and benefits between residents and fellows

Fiscal Note: Minimal

REFERENCES:

1. ACGME. Funding for Graduate Medical Education. 2022. https://www.acgme.org/globalassets/pdfs/funding-for-graduate-medical-education-5.3.2022.pdf
2. Heisler, E., Mendez, B., Mitchell, A., Panangala, S.V, Villagrana, M. (2018) Federal Support for Graduate Medical Education: An Overview (CRS Report No. R44376) Retrieved from Congressional Research Service Website: Federal Support for Graduate Medical Education: An Overview (congress.gov)
3. AAMC. Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident and Advisor needs to know. 2019. https://www.aamc.org/media/71701/download?attachment
4. Committee on the Governance and Financing of Graduate Medical Education; Board on Health Care Services; Institute of Medicine; Eden J, Berwick D, Wilensky G, editors. Graduate Medical Education That Meets the Nation's Health Needs. Washington (DC): National Academies Press (US); 2014 Sep 30. 3, GME Financing. Available from: https://www.ncbi.nlm.nih.gov/books/NBK248024/
5. 42 CFR 413.78 Direct GME payments: Determination of the total number of FTE residents; 42 CFR 413.75(b) Direct GME payments: General requirements.
6. 42 CFR 413.75(b) Direct GME payments: General requirements

RELEVANT RFS POSITION STATEMENTS:

291.009R Resident and Fellow Bill of Rights
That our AMA-RFS support a Residents' and Fellows' Bill of Rights that will serve as a testament to the organization's support for and commitment to the education and training of competent, conscientious residents and fellows by illuminating their rights and advocating for provisions that it believes all residents should be afforded, and that have not yet been designated as rights, and that residents and fellows have a right to: A. An education that fosters professional development, takes priority over service, and leads to independent practice. With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care, including but not limited to membership to medical libraries, remote access to medical journals, and other online or mobile resources; (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings; (6) Financial support or reimbursement for board certification, medical licensing examinations (such as the USMLE STEP 3 or specialty-specific testing), and educational conferences, to reduce the financial burden residents and fellows face; and (7) Opportunities to advance career development, such as access to leadership roles on hospital committees and adequate paid time off for job and fellowship interviews. B.

Appropriate supervision by qualified faculty with progressive resident responsibility toward independent practice. With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents. C. Regular and timely feedback and evaluation based on valid assessments of resident performance. With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and re-credentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request. D. A safe and supportive workplace with appropriate facilities. With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract. E. Adequate compensation and benefits that provide for resident well-being and health. (1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal; and c. Recognition as full-time workers and a right to unionize, granting residents and fellows the ability to advocate collectively to employers and lawmakers on behalf of patients and themselves as workers, not only as learners. (2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should enable trainees to support their families and pay educational debts, reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living and differences based on geographical location. (3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks without pressure to leave it unused or penalization for its use; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided. F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education. With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented; and (3) Adequate hospital staffing and support, including the maintenance of back-up call schedules for every residency program. G. Due process in cases of allegations of misconduct or poor performance. With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA. H. Access to and protection by institutional and accreditation authorities when reporting violations. With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or

complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey. 2. That our AMA-RFS review and update the Residents' and Fellows' Bill of Rights at a minimum every ten years. (Resolution 1, A-09; Report C, A-21) (Reaffirmed Resolution 4 & 15, A-23)

291.018R Fellowship Salaries:
That our AMA: (1) study the current system of fellowship funding and salaries with a report at I-02, and (2) encourage the ACGME and the ABMS to collect information on fellowship salaries from both accredited and nonaccredited programs to serve as a basis for the development of policy recommendations. (Report G, A-02) (Reaffirmed Report D, I-16)

291.031R Sick Leave for Resident Physicians:
That our AMA-RFS: (1) oppose the inappropriate use of sick leave in the workplace; and (2) support allowing residents to be absent for illness or surgery for a reasonable period of time without being penalized, within the parameters of the Accreditation Council of Graduate Medical Education (ACGME) and Residency Review Committee (RRC) requirements. (Substitute Resolution 2, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16) ((Reaffirmed Resolution 6, I-17)

291.034R Residents' Benefits:
That our AMA-RFS support ongoing long-range planning and strategy development to improve the vocational, personal, and educational benefits of residents. (Substitute Resolution 1, A-81) (Reaffirmed Report C, I-91) (Reaffirmed Report C, I-01)(Reaffirmed Report D, I-16)

293.001R Physician Scientist Benefit Equity:
That our AMA-RFS support the concept that all resident and fellow physicians who function in a role as physician scientists are provided with benefits packages comparable to those provided to their peers in clinical residencies or fellowships. (Resolution 1, A-07)

293.011R Benefit Packages for Resident Physicians:
That our AMA-RFS support that: (1) all institutions be required to provide their resident physicians with disability insurance, life insurance, HIV indemnity, malpractice insurance including tail coverage, retirement benefits, health, sick leave and wages commensurate with their education and experience; and (2) if a given benefit or salary is provided to some residents within a given program at the same postgraduate level, then that benefit must be provided to all residents, but this provision should not be used to eliminate the benefit in question. (Substitute Resolution 13, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

280.001R Principles of GME Funding Reform:
That our AMA-RFS support: (1) that federal funding for Graduate Medical Education (GME) should be based on the actual cost of training residents and fellows (including but not limited to salary, benefits, and institutional support for training and education) and include yearly adjustments for geographic and inflation-based cost-of-living; (2) that the allocation of GME funds within an institution should be transparent and accountable to all stakeholders; (3) that funding for GME should strive to meet the health needs of the public including but not limited to the size of the training program, geographic distribution, and specialty mix; (4) that federal funding for GME from the Centers for Medicare/Medicaid Services or any federal successors should be disbursed through a single transparent funding stream while maintaining opportunities for a multi-payor system; and (5) additional federal funding for the GME that provides flexibility for innovation in training and education above and beyond current levels of funding. (Resolution 20, A-15)

280.005R Comparable Financial Support for Residents:
That our AMA-RFS support a comparable level of financial support of housestaff positions by level of training within institutions. (Report I, I-95) [See also: AMA Policy H-310.988] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

280.011R Medicare Reimbursement of Direct GME Funding:
That our AMA-RFS support restoration of Direct Graduate Medical Education funding that allows each resident an initial residency period of five years, regardless of specialty choice or minimum years to attain board certification. (Late Resolution 2, I-96) (Reaffirmed Report C, I06) (Reaffirmed Report D, I-16)

280.014R Reinstatement of Full Medicare Payment for Second Residencies in Primary Care or Shortage Specialties:
That our AMA-RFS support full Medicare Direct Graduate Medical Education reimbursement to training hospitals for residents who have the minimum years of training for first board eligibility and who are seeking to enter a postgraduate training program in a primary care or shortage specialty. (Resolution 37, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16) 280.015R UGraduate Medical Education FundingU: That our AMA-RFS support: (1) monitoring and reporting on Medicare Graduate Medical Education funding; and (2) publicizing and educating trainees on the issue of Medicare GME funding. (Report E, I-91) (Reaffirmed Report C, I-01) [See also: AMA Policy H-305.956] (Reaffirmed Report D, I-16)

RELEVANT AMA POLICY:

Onsite and Subsidized Childcare for Medical Students, Residents and Fellows H-200.948
Our AMA recognizes: (1) the unique childcare challenges faced by medical students, residents and fellows, which result from a combination of limited negotiating ability (given the matching process into residency), non-traditional work hours, extended or unpredictable shifts, and minimal autonomy in selecting their work schedules; and (2) the fiscal challenges faced by medical schools and graduate medical education institutions in providing onsite and/or subsidized childcare to students and employees, including residents and fellows.

Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians H-345.973
Our AMA promotes the availability of timely, confidential, accessible, and affordable medical and mental health services for medical students and resident and fellow physicians, to include needed diagnostic, preventive, and therapeutic services. Information on where and how to access these services should be readily available at all education/training sites, and these services should be provided at sites in reasonable proximity to the sites where the education/training takes place. [Res. 915, I-15; Revised: CME Rep. 01, I-16]

Financial Protections for Doctors in Training H-310.903
Our AMA supports the availability of retirement plans for residents and fellows at all teaching institutions that are no less favorable than those offered to other institution employees. [BOT Rep. 18, I-21]

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 will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
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 encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. 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 physician faculty with progressive resident responsibility toward independent practice.
With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.
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 retirement plan options, 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.
9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.
10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual’s training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).
11.The Residents and Fellows’ Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.
12. Our AMA will distribute and promote the Residents and Fellows’ Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles, including resident/fellow empowerment and peer-selected representation in institutional leadership.
13. Our AMA encourages development of accreditation standards and institutional policies designed to facilitate and protect residents/fellows who seek to exercise their rights.
14. Our AMA encourages the formation of peer-led resident/fellow organizations that can advocate for trainees’ interests, as outlined by the AMA’s Residents and Fellows’ Bill of Rights, at sponsoring institutions. [CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21;

Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22; Reaffirmed in lieu of: Res. 307, I-22; Modified: CME Rep. 05, I-23]

Resident and Fellow Access to Fertility Preservation H-310.902
Our AMA: (1) encourages insurance coverage for fertility preservation and infertility treatment within health insurance benefits for residents and fellows offered through graduate medical education programs; and (2) supports the accommodation of residents and fellows who elect to pursue fertility preservation and infertility treatment, including but not limited to, the need to attend medical visits to complete the gamete preservation process and to administer medications in a time-sensitive fashion. [Res. 302, A-22]

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will 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; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.

14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.
32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.
33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.
34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.
(Appended: Res. 202, I-22)

Insurance Coverage for Medical Students and Resident Physicians H-295.942
1. Our AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance.
2. Our AMA encourages medical schools to allow students and their families who qualify for and enroll in health insurance plans other than the institutionally offered health insurance plans, to be exempt from an otherwise mandatory student health insurance plan requirement, provided that the alternative plan has comparable care coverage and is accepted at the primary geographic locations of training.
3. Our AMA supports the continuation of comprehensive medical insurance benefits for inactive students taking an approved leave of absence during their time of degree completion and encourage medical schools to publicize their policies regarding the continuation of insurance benefits during leaves of absence. [Appended: Res. 304, I-23]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 16
(A-24)

Introduced by: Karen Dionesotes, MD, MPH, Sophia Spadafore, MD, Luis Seija, MD, Helene Nepomuceno, MD, Karthik V. Sarma, MD, PhD

Subject: Public Health Implications of US Food Subsidies

Referred to: Reference Committee

Whereas, our American Medical Association (AMA) is committed to promoting the betterment of public health and has long supported policies that aim to improve dietary and nutritional standards in the United States; and

Whereas, the United States government, through various subsidies, supports the production of certain agricultural commodities which plays a role in shaping agricultural policy and food systems; and

Whereas, US agricultural subsidies have historically favored the production of crops including corn, soybeans, wheat, and rice, which are often processed into ingredients like high-fructose corn syrup, refined grains, and vegetable oils, commonly used in the production of processed food[1-3]; and

Whereas, overconsumption of processed foods which are high in added sugar, unhealthy fats and refined carbohydrates is associated with an increased risk for diabetes, obesity, and other chronic diseases[1-5]; and

Whereas, US agricultural subsidies can affect the relative prices of different foods, making some food less expensive and more accessible, while potentially making others relatively more expensive. This can influence consumer choices, potentially contributing to the consumption of less healthy foods and beverages[2-5]; and

Whereas, the availability and affordability of subsidized foods may influence dietary choices and nutritional intake, particularly among low-income populations, which may contribute to poor dietary quality and negative health outcomes[2,4,5]; and

Whereas, intensive monoculture farming is an agricultural practice supported by subsidies, which has negative environmental consequences including soil degradation, water pollution and greenhouse gas emissions[6]; and

Whereas, environmental degradation can indirectly impact public health by compromising food and water security and contributing to climate change-related health risks; and

Whereas, while agricultural subsidies are intended to support agricultural production and stabilize food prices, there are unintended consequences on public health, especially when they disproportionately benefit certain crops or food groups, and disproportionately harm low-income populations; and

Whereas, there is a need for a comprehensive review of food subsidies to evaluate their impact on dietary patterns, health disparities, and overall public health, aiming for alignment with nutritional guidelines that promote wellness and disease prevention; therefore be it

RESOLVED, that our American Medical Association (AMA) study the public health implications of United States Food Subsidies, focusing on: (1) how these subsidies influence the affordability, availability, and consumption of various food types across different demographics; (2) potential for restructuring food subsidies to support the production and consumption of more healthful foods, thereby contributing to better health outcomes and reduced healthcare costs related to diet-related diseases; and (3) avenues to advocate for policies that align food subsidies with the nutritional needs and health of the American public, ensuring that all segments of the population benefit from equitable access to healthful, affordable food.

Fiscal Note: Moderate

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RELEVANT RFS POSITION STATEMENTS:

120.001R U.S. Farm Subsidies
That our AMA-RFS support reform and updates to the US Farm Bill including redirecting subsidies in the US Farm Bill that perpetuate calorie dense, nutrition-poor products toward programs aimed at combating obesity. (Resolution 1, I-11)

RELEVANT AMA POLICY:

The Health Effects of High Fructose Syrup H-150.919
Our AMA: (1) recognizes that at the present time, insufficient evidence exists to specifically restrict use of high fructose corn syrup (HFCS) or other fructose-containing sweeteners in the food supply or to require the use of warning labels on products containing HFCS; (2) encourages independent research (including epidemiological studies) on the health effects of HFCS and other added sugars, and evaluation of the mechanism of action and relationship between fructose dose and response; and (3) in concert with the Dietary Guidelines for Americans, recommends that consumers limit the amount of added sugars in their diet. [CSAPH Rep. 8, A-23]

Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners H-150.927
Our AMA: (1) acknowledges the adverse health impacts of sugar- sweetened beverage (SSB) consumption and food products with added sugars, and support evidence-based strategies to reduce the consumption of SSBs and food products with added sugars, including but not limited to, excise taxes on SSBs and food products with added sugars, removing options to purchase SSBs and food products with added sugars in primary and secondary schools, the use of warning labels to inform consumers about the health consequences of SSB consumption and food products with added sugars, and the use of plain packaging; (2) encourages continued research into strategies that may be effective in limiting SSB consumption and food products with added sugars, such as controlling portion sizes; limiting options to purchase or access SSBs and food products with added sugars in early childcare settings, workplaces, and public venues; restrictions on marketing SSBs and food products with added sugars to children; and changes to the agricultural subsidies system; (3) encourages hospitals and medical facilities to offer healthier beverages, such as water, unflavored milk, coffee, and unsweetened tea, for purchase in place

of SSBs and apply calorie counts for beverages in vending machines to be visible next to the price; (4) encourages physicians to (a) counsel their patients about the health consequences of SSB consumption and food products with added sugars and replacing SSBs and food products with added sugars with healthier beverage and food choices, as recommended by professional society clinical guidelines; and (b) work with local school districts to promote healthy beverage and food choices for students; (5) recommends that taxes on food and beverage products with added sugars be enacted in such a way that the economic burden is borne by companies and not by individuals and families with limited access to food alternatives; (6) supports that any excise taxes are reinvested in community programs promoting health and (7) will advocate for the end of tax subsidies for advertisements that promote among children the consumption of food and drink of poor nutritional quality, as defined by appropriate nutritional guiding principles. [CSAPH Rep. 03, A-17; Modified: Res. 429, A-22]

Reform the US Farm Bill to Improve US Public Health and Food Sustainability H-150.932
Our AMA supports the creation of a new advisory board to review and recommend US Farm Bill budget allocations to ensure any government subsidies are only used to help produce healthy food choices and sustainable foods, and that advisory committee members include physicians, public health officials and other public health stakeholders. [Res. 215, A-13; Reaffirmed: BOT Rep. 09, A-23]

Combating Obesity and Health Disparities H-150.944
Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol. [Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 17
(A-24)

Introduced by: Luis Seija, MD, Karthik V. Sarma, MD, PhD, Pauline Huynh, MD, Jacob Altholz, MD, Helene Nepomuceno, MD, Hari Iyer, MD

Subject: Support for Paid Sick Leave

Referred to: Reference Committee

Whereas, sick leave can be used by employees to recover from illness, attend medical appointments, care for sick relatives, and seek assistance for domestic violence, and access disproportionately impacts women who take on caregiver responsibilities[1-4]; and

Whereas, all but 10 countries feasibly fund paid sick leave via governments and/or employers, but the US' Family and Medical Leave Act (FMLA) only ensures unpaid leave[5-7]; and

Whereas, 75% of voters support a national paid leave policy, but currently 25% of private sector workers do not receive paid sick leave, including 62% of those in the lowest income decile, 45% of those in the lowest income quartile, 54% of Latine workers, 47% of Indigenous workers, and 38% of Black workers[8-11]; and

Whereas, multiple studies demonstrate that paid sick leave increases primary care use and reduces occupational injuries and infectious spread, with one estimating over $1 billion in annual savings from over 1 million prevented ED visits[12-22]; and

Whereas, paid sick leave is guaranteed in 15 states including DC, 4 counties, and 17 cities, with early adopters showing sustainable success for over a decade[2,23-24]; and

Whereas, the Healthy Families Act would guarantee paid sick leave and is currently being considered in both the House and Senate[25]; therefore be it

RESOLVED, that our AMA-RFS supports advocacy that guarantees employee access to protected paid sick leave.

Fiscal Note: Minimal

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RELEVANT RFS POSITION STATEMENTS:

291.031R Sick Leave for Resident Physicians
That our AMA-RFS: (1) oppose the inappropriate use of sick leave in the workplace; and (2) support allowing residents to be absent for illness or surgery for a reasonable period of time without being penalized, within the parameters of the Accreditation Council of Graduate Medical Education (ACGME) and Residency Review Committee (RRC) requirements. (Substitute Resolution 2, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16) (Reaffirmed Resolution 6, I-17)

RELEVANT AMA POLICY:

H-420.979 AMA Statement on Family, Medical, and Safe Leave
Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:
1) Medical leave for the employee, including pregnancy, abortion, and stillbirth; 2) Maternity leave for the employee-mother; 3) Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; 4) Leave for adoption or for foster care leading to adoption; and 5) Safe

leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking. Such periods of leave may differ with respect to each of the foregoing classifications and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.
Our AMA recognizes the positive impact of paid safe leave on public health outcomes and supports legislation that offers safe leave. [BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22; Appended: Res. 413, A-23; Modified: Res. 424, A-23]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 18
(A-24)

Introduced by: Karen Dionesotes, MD, MPH, Sophia Spadafore, MD, Luis Seija, MD, Helene Nepomuceno, MD, Jacob Altholz, MD, Karthik V. Sarma, MD, PhD, Hari Iyer, MD

Subject: Improving Medigap Protections

Referred to: Reference Committee

Whereas, traditional Medicare is widely accepted and portable, helping to provide reliable coverage to those who qualify;[1] and

Whereas, many Medicare beneficiaries purchase Medicare Supplement (Medigap) plans (23%) or opt for Medicare Advantage plans (51%) to help mitigate out-of-pocket costs and obtain services not covered under Traditional Medicare[2-4] ; and

Whereas, the average monthly premium for Medigap plans is $138, a prohibitively high cost for many seniors that drives them to other options including Medicare Advantage[5] ; and

Whereas, Medicare beneficiaries who are dually qualified for Medicaid benefit from robust financial assistance for supplemental insurance, but this only applies to a subset of the population, leaving many without financial assistance[6] ; and

Whereas, Medicare Advantage plans, which are administered by private insurers, are often limited by geographically biased provider networks, restrictive enrollment periods, and prohibition of simultaneous Medigap enrollment[3,7-8]; and

Whereas, Medicare Advantage organizations sometimes delay or deny Medicare Advantage beneficiaries' access to services, despite requests aligning with Medicare coverage rules, and also exhibit higher disenrollment rates amongst racial and ethnic minority beneficiaries[9-11]; and

Whereas, Medigap plans are tightly regulated by the Centers for Medicare and Medicaid Services (CMS) and are among the most popular supplemental insurance plans for Traditional Medicare beneficiaries with over 14 million enrollees[12,13]; and

Whereas, those 65 or older with Medicare Part B are eligible and encouraged to buy Medigap policies during the one-time six month enrollment period that starts with their Medicare Part B registration; thereafter, there is no guarantee that an insurance company will enroll beneficiaries unless they meet medical underwriting requirements[13]; and

Whereas, beneficiaries over age 65 subscribed to a Medigap policy have certain protections during the six month enrollment period, including Guaranteed Issue, which requires insurers to permit enrollment regardless of health status, age, gender, or other factors that might predict the use of health services, and Community Rating, which prevents insurers from charging beneficiaries higher premiums based on age, gender, health status, or claims history[14]; and

Whereas, community rating and guaranteed issue protections were passed as part of the Affordable Care Act (ACA) for nationally available commercial insurance plans, but weren't extended to Medigap plans[15]; and

Whereas, the ACA allows for modified community ratings depending on age (max ratio of 3:1), tobacco use (max ratio of 1.5:1), geographic area, and family size[16]; and

Whereas, currently, there is no federal requirement for insurers to make Medigap policies available to Medicare beneficiaries under the age of 65 with disabilities or End Stage Renal Disease (ESRD)[17-18]; and

Whereas, individual states have the latitude to offer varying degrees of consumer protection, consequently, state-specific Medigap regulations in 14 states make it that all Medigap plans are available to Medicare beneficiaries, including restrictions on premiums, regardless of age[19-20]; and

Whereas, in the remaining 36 states, Medigap plans available for young disabled and ESRD beneficiaries either charge significantly high premiums, offer limited plan and coverage options, or have no provisions geared to the under-65 population[20-21]; and

Whereas, AMA Policy H-330.896 expresses support for aligning Medicare age-eligibility and incentives to match the Social Security schedule, consistent with aligning Medigap coverage to Medicare beneficiaries under 65; and

Whereas, as of 2018, only eight states go beyond the federal minimum protections and instead mandate that Medigap carriers to use lifetime Community Rating, and just four states have Guaranteed Issue protections[23-24]; and

Whereas, high-need beneficiaries were are much more likely to re-enroll in Medicare Advantage after switching to Traditional Medicare in states that did not provide community rating and guaranteed issue protections[25]; and

Whereas, States with community rating and guaranteed issue protections for Medigap enrollees have higher premiums, resulting in decreased enrollment[26]; and

Whereas, the higher average Medigap monthly premium cost in states with community rating and guaranteed issue can partially be explained by the higher cost of living in these states compared to the national average[27-28]; and

Whereas, Congress is currently investigating private health insurance companies' dubious marketing tactics to steer consumers into purchasing more expensive Medigap plans, representing a timely opportunity for regulatory reform[24,29]; therefore be it

RESOLVED, that our AMA-RFS support annual open enrollment periods and guaranteed lifetime enrollment eligibility for Medigap plans; and be it further

RESOLVED, that our AMA-RFS support advocacy for the extension of modified community rating regulations, similar to those enacted under the Affordable Care Act for commercial insurance plans, to Medigap supplemental insurance plans; and be it further

RESOLVED, that our AMA-RFS support efforts to expand access to Medigap policies to individuals under 65 years of age with disabilities or end-stage renal disease who qualify for Medicare benefits; and be it further

RESOLVED, that our AMA-RFS support efforts to improve the affordability of Medigap supplemental insurance for lower income Medicare beneficiaries.

Fiscal Note: Minimal

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RELEVANT AMA POLICY:

Health Insurance Market Regulation H-165.856
Our AMA supports the following principles for health insurance market regulation: (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan. (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection. (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges. (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium. (5) Insured individuals should be protected by guaranteed renewability. (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices. (7) Guaranteed issue regulations should be rescinded. (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage. (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

Increasing Coverage for Children H-165.877
Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic

areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.

Strategies to Strengthen the Medicare Program H-330.896
Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate: 1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure. 2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard-setting and regulatory oversight of plans. 3. Restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 19
(A-24)

Introduced by: Luis Seija, MD, Helene Nepomuceno, MD, Ida Vaziri, MD, Jacob Altholz, MD, Karthik V. Sarma, MD, PhD, Pauline Huynh, MD

Subject: Supporting the Patient's Right to Vote

Referred to: Reference Committee

Whereas, our American Medical Association "acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric"; and be it further

Whereas, our AMA "will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes"; and

Whereas, the Association of American Medical Colleges (AAMC) supports medical schools and teaching hospitals facilitating nonpartisan voter registration efforts[1]; and

Whereas, a growing body of research demonstrates the relationship between the political determinants of health (including voter rates, government participation, and policy engagement) and other social determinants, including how votes lost to morbidity and mortality in underrepresented populations impact electoral and policy outcomes[2-4]; and

Whereas, lower voter rates among elderly patients, patients with disabilities, patients who are socially isolated, and low-income patients are associated with poor reported health, and increased voter rates are associated with healthier lifestyle behaviors and improved mental health, even when controlling for income inequality[4-10]; and be it further

Whereas, health facilities' nonpartisan voter registration efforts demonstrate improved civic engagement and are protected by the National Voter Registration Act and IRS code[11-14]; and

Whereas, emergency absentee ballot access for people experiencing or managing medical emergencies is variable across states, with only 23 offering coverage for patients' relatives and only 17 extending protections to healthcare workers[12]; and

Whereas, physician voter rates are lower than the general public, often due to work conflicts, although rates are higher in states with universal mail ballots[15-16]; and

Whereas, 1.2 million Native Americans (34%) are not registered to vote due to vast differences in experiences and opportunities, especially for voters on reservations who experience discrimination and unique challenges with voter identification laws (e.g., no addresses on reservations, inability to use tribal-federal membership cards)[18-23]; and

Whereas, the distinct political and dual citizenship status of Native Americans as members of sovereign Tribal nations underscores the importance of their voter participation, as federal and state elected officials are responsible for working with their Tribal governments to enact laws governing Tribal authority and treaty rights[20]; and

Whereas, as Native Americans comprise over 10% of the electorate in many states, Congress has repeatedly introduced the Native American Voting Rights Act, which would in part establish a Native American voting task force grant program to increase turnout[20]; and

Whereas, President Biden's Executive Order on Promoting Access to Voting strongly encourages federal agencies, including Veterans Health Administration (VHA) and Indian Health Service sites to seek designation as voter registration sites[24]; and

Whereas, other federal health and social programs such as the VHA, Medicaid, and SNAP/WIC offer voter registration services, and the Health Resources and Services Administration even offers guidance for Federally Qualified Health Centers to organize such efforts[12,25-26]; and

Whereas, civic engagement efforts are limited at Indian Health Service, Tribal, and Urban Indian Health Programs, which are crucial interfaces with Native American patients and Tribal governments[27-28]; therefore be it

RESOLVED, that our AMA-RFS support efforts to engage physicians and other healthcare workers in nonpartisan voter registration efforts in healthcare settings, including emergency absentee ballot procedures for qualifying patients, visitors, and healthcare workers; and be it further

RESOLVED, that our AMA-RFS support Indian Health Service, Tribal, and Urban Indian Health Programs becoming designated voter registration sites to promote nonpartisan civic engagement among the American Indian and Alaska Native population.

Fiscal Note: Minimal

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RELEVANT RFS POSITION STATEMENTS:

540.001R Election Day Voting Time: That our AMA-RFS: (1) encourage state medical societies to inform residents and students of local voter laws to include education on absentee balloting; and (2) encourage medical schools and residency training programs to define mechanisms specific to their institution to allow residents and students the opportunity to vote in local and national elections. (Substitute Resolution A-95) [See also: AMA Policy H-565.991] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

RELEVANT AMA POLICY:

Support for Safe and Equitable Access to Voting H-440.805
1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA: (a) acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric; (b) recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; and (c) will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes.

Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections D-65.982
Our AMA will: (1) study the rate of voter turnout in physicians, residents, fellows, and medical students in federal and state elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community; and (2) work with appropriate stakeholders to ensure that medical students, residents, fellows and physicians are allowed time to vote without penalty on Election Days.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 20
(A-24)

Introduced by: Sophia Spadafore, MD, Jacob Altholz, MD, Luis Seija, MD, Helene Nepomuceno, MD, Karthik V. Sarma, MD, PhD, Pauline Huynh, MD

Subject: Opposing Pay-to-Stay Incarceration and Probation Supervision Fees

Referred to: Reference Committee

Whereas, fines are monetary sanctions opposed as a sentence or part of a sentence for a civil or criminal offense[1]; and

Whereas, fees are additional charges assessed in the civil or criminal legal system and can include the cost of creating a court transcript, room and board for a period or incarceration, and surcharges, which are fees charged to help fund a particular government function or contribute to a jurisdiction's general review[1]; and

Whereas, restitution is a financial sanction intended to compensate victims of an offense for actual losses[1]; and

Whereas, financial sanctions are the combination of fines, fees, and restitution that may be imposed for an offense adjudicated in the criminal or legal system[1]; and

Whereas, "Pay-to-stay" fees require individuals to pay for their own imprisonment to cover housing and food costs and are used in 49 states, including $249 daily in Connecticut, $80 daily in Maine and Kentucky, $66 daily in Ohio, and $20 daily in Alabama[2-6]; and

Whereas, average hourly wages during incarceration are $0.13 to $1.30 per hour, and in the first year after release, 49% earn $500 or less and 80% earn less than $15,000[7-8]; and

Whereas, because only 10-15% are ever collected, pay-to-stay fees do not significantly contribute to prison budgets, but permanently damage the credit records of individuals leaving incarceration if not paid within 180 days after release and harm future prospects for stable employment and housing[6,9,10]; and

Whereas, pay-to-stay fees keep formerly incarcerated individuals trapped in a cycle of poverty and imprisonment, as debts hinder re-entry, contribute to recidivism, and force individuals to forgo basic necessities in order to make payments[11-13]; and

Whereas, there are over 3.5 million people serving terms of probation in the United States[14]; and

Whereas, 48 states have laws that allow people on probation to be charged a monthly supervision fees, which can range from $10-$150, and fixed fees set by probation terms can cost between $30 and $600, which means that someone on probation for five years can pay as much as $9,000 in supervision fees[14]; and

Whereas, people who are unable to pay the full amount upfront then may have to pay additional fees including a fee for entering a payment plan, interest on the total amount, and are at risk for additional punishment; and

Whereas, many states sentence people to probation supervision in conjunction with their financial sanctions, making payment a condition of probation[14]; and

Whereas, disproportional fines and fees can keep individuals involved in the criminal justice system trapped in a cycle of poverty and imprisonment, as debts hinder re-entry, contribute to recidivism, and force individuals to forgo basic necessities in order to make payments; therefore be it

RESOLVED, that our AMA-RFS oppose fees charged to incarcerated individuals for room and board and supports federal and state efforts to repeal statutes and ordinances which permit inmates to be charged for room and board; and be it further

RESOLVED, that our American Medical Association (AMA) oppose probation and parole supervision fees and supports federal and state efforts to repeal statutes and ordinances which permit individuals on probation or parole to be charged for supervision fees.

Fiscal Note: Minimal

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RELEVANT RFS POSITION STATEMENTS:

410.032R Coordinating Correctional and Community Healthcare:
That our AMA-RFS support: (1) linkage of those incarcerated to community clinics upon release in order to accelerate access to primary care and improve health outcomes among this vulnerable patient population as well as adequate funding; and (2) the collaboration of correctional health workers and

community health care providers for those transitioning from a correctional institution to the community. (Resolution 10, A-18)

RELEVANT AMA POLICY:

D-430.992 Reducing the Burden of Incarceration on Public Health
1. Our AMA will support efforts to reduce the negative health impacts of incarceration, such as: (1) implementation and incentivization of adequate funding and resources towards indigent defense systems; (2) implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records; and (3) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings.
2. Our AMA will partner with public health organizations and other interested stakeholders to urge Congress, the Department of Justice, the Department of Health and Human Services, and state officials and agencies to minimize the negative health effects of incarceration by supporting programs that facilitate employment at a living wage, and safe, affordable housing opportunities for formerly incarcerated individuals, as well as research into alternatives to incarceration. [Res. 902, I-22]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 21
(A-24)

Introduced by: Helene Nepomuceno, MD, Ida Vaziri, MD, Karthik V. Sarma, MD, PhD, Pauline Huynh, MD, Jacob Altholz, MD, Luis Seija, MD

Subject: Infertility Coverage

Referred to: Reference Committee

Whereas, fertility assistance and preservation are commonly used by patients diagnosed with or at risk for infertility (including iatrogenic infertility due to medical interventions, such as cancer treatment or hormone replacement therapy), LGBTQ+ patients, military and veteran patients, and patients who desire future pregnancy at advanced reproductive age[1-2]; and

Whereas, cost for services such as in vitro fertilization or oocyte cryopreservation ranges from $10,000 to $13,000, not including medications, further tests, multiple cycles, and cryostorage fees[3-5]; and

Whereas, the average cost for semen analysis by emission is around $750, with additional costs for cryostorage[6]; and

Whereas, cost due to lack of insurance coverage and need for supplemental insurance is the most common barrier for patients with infertility, often leading them to end treatment[7-8]; and

Whereas, in states where employer plans cover assisted reproductive technology, the cost of in vitro fertilization (IVF) is 13% of average annual disposable income compared to 52% in other states, indicating that coverage regulations drastically affect affordability[9]; and

Whereas, Medicaid covers fertility drugs in only one state, covers infertility diagnostics in only a few states, and does not cover other fertility assistance or preservation services[10]; and

Whereas, TRICARE only covers infertility care that enables “natural conception,” and the VA only covers care for infertility due to service-related injuries and only if donor eggs and sperm are from a couple, excluding LGBTQ+ and unmarried individuals[10]; and

Whereas, 25 states and DC have various regulations at least partially restricting coverage of some fertility diagnostics or services in at least a portion of employer plans offered, although sex and gender-based restrictions, cost-sharing, age cutoffs, marital requirements, exemptions for small and large employers, and other stipulations vary widely[10-14]; and

Whereas, states with private coverage for fertility services do not experience significant premium increases, with estimates ranging from 0.5-1% ($1-5), while demonstrating 150-300% greater use of fertility services compared to states without[10,15-17]; and

Whereas, Black women may have higher infertility rates but are less likely to use fertility services, and Black, Hispanic, and Asian women all experience poorly understood lower success rates for fertility services, alongside many financial and logistic barriers[18-20]; and

Whereas, women of color also report hearing comments disregarding their fertility concerns or perpetuating stereotypes (that they can become pregnant easily or that they should not become pregnant at all)[20]; and

Whereas, LGBTQ+ individuals and unmarried individuals are often excluded from conditions and requirements for fertility services[10,11,21,22]; and

Whereas, unlike the IHS, other federal health programs such as the Veterans Health Administration and Federal Employees Health Benefit Program, provide a spectrum of coverage for infertility diagnostics and treatment[23]; and

Whereas, the prevalence of infertility and impaired fecundity (reproductive fitness) among American Indian and Alaska Native (AI/AN) persons is 7.0% and 13.2%, respectively, which is greater than that of the U.S. population (6.4% and 11.0%)[24]; and

Whereas, positive pregnancy (PP) and ongoing pregnancy/delivery (OP/D) rates are estimated to be 15% and 10% per IUI cycle in the general population, respectively, but AI/AN patients have marked PP/OP/D disparities (5.10% PP and 3.3% OP/D)[25]; and

Whereas, the IHS defines Level 5 (Excluded Services) as services and procedures considered purely cosmetic in nature, experimental or investigational, or with no proven medical benefit and includes IVF and related services in this category, preventing IHS, Tribal, and Urban Indian Health Programs from paying for this care[26-28]; therefore be it

RESOLVED, that our AMA-RFS supports federal protections that ensure insurance coverage by all payers for the diagnosis and treatment of recognized infertility; and be it further

RESOLVED, that our AMA-RFS supports studying the feasibility of insurance coverage for fertility preservation for reasons other than iatrogenic infertility.

Fiscal Note: Minimal

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RELEVANT RFS POSITION STATEMENTS:

390.007R Oncofertility and Fertility Preservation Treatment: That our AMA-RFS: (1) support coverage for standard fertility preservation therapy by all payers when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician; and (2) advocate for appropriate legislation requiring coverage for fertility preservation therapy services when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician. (Resolution 6, A-12) (Reaffirmed Report E, A22)

410.026R Insurance Coverage for Fertility Preservations in Patients Receiving Cytotoxic or Immunomodulatory Agents: That our AMA-RFS support: (1) payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or by necessary cytotoxic and/or immunomodulatory therapies as determined by a licensed physician; and (2) lobbying for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary cytotoxic and/or immunomodulatory therapies as determined by a licensed physician. (Resolution 5, A-14)

RELEVANT AMA POLICY

H-185.990 Infertility and Fertility Preservation Insurance Coverage
1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a

licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician. [Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended Res. 114, A-13; Modified: Res. 809, I-14]

H-65.956 Right for Gamete Preservation Therapies
1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies. [Res. 005, A-19]

H-185.922 Right for Gamete Preservation Therapies
3. Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility. [Res. 005, A-19]

H-510.984 Infertility Benefits for Veterans
1. Our AMA supports: (A) lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries; and (B) efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries; and (C) additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
2. Our AMA encourages: (A) interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries, and (B) the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process. [CMS Rep. 01, I-16; Appended: Res. 513, A-19]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 22
(A-24)

Introduced by: Whitney Sambhariya, MD, PhD, Luis Seija, MD, Karthik V. Sarma, MD, PhD, Pauline Huynh, MD, Sophia Spadafore, MD, Hari Iyer, MD

Subject: Medicaid & CHIP Benefit Improvements

Referred to: Reference Committee

Whereas, the Centers for Medicare and Services list hearing, vision, and dental care as optional benefits in Medicaid, and states vary drastically in Medicaid coverage of these services; and

Whereas, Medicaid is not subject to Medicare's budgetary constraints, and much of the cost of improved benefits is borne by existing federal agreements for Medicaid expansion funding; and

Whereas, only 28 states provide varying levels of hearing coverage based on hearing loss severity, 18 states offer no coverage, and some only cover devices but not services;[2] and

Whereas, of the 28 states providing some Medicaid hearing coverage, a study rated only 6 as "fair" (on a scale of poor, fair, good, excellent);[2] and

Whereas, Medicaid patients are more likely to report hearing problems compared to privately insured patients, and lower-income patients are twice as likely to experience more difficulty using hearing aids, in part due to the cost of required support services;[3,4] and

Whereas, while FDA approval of over-the-counter hearing aids is expected to greatly increase access, a pair can still cost $1,000, a prohibitive cost for many Medicaid patients;[5-6] and

Whereas, only 33 states offer some Medicaid vision coverage, with 28 limiting access based on severity of vision impairment, pre-existing conditions, restrictions to only eyeglasses and not contacts, number of visits allowed, and approval of coverage only every 2 to 4 years;[7] and

Whereas, a *JAMA Ophthalmology* study found that Medicaid patients had significantly decreased odds of securing an appointment compared to privately insured patients (OR=0.41);[8] and

Whereas, a study in *Ophthalmology* (the journal of the American Academy of Ophthalmology) found that Medicaid patients are over twice as likely to not receive follow-up care after glaucoma diagnosis compared to privately insured patients;[9] and

Whereas, no minimum requirements for Medicaid dental coverage exist, and in 2019, only 19 states offered comprehensive coverage, while 31 offered limited/emergency coverage;[10-13] and

Whereas, 18% of Medicaid patients under 65 report an unmet dental need due to cost, double the rate of privately insured patients;[4] and

Whereas, up to 25% of non-elderly adults forgo dental care due to cost, as the average yearly cost of dental care for adults under the poverty level is $523;[14-15] and

Whereas, adults in poverty are three times as likely to develop dental caries, and 29% of low-income adults report that appearance of their teeth affects their employment chances;[16-17] and

Whereas, Medicaid patients with dental coverage are more likely to seek dental care due to reduced out-of-pocket cost and receive dental caries treatment than those without;[18] and

Whereas, our 2 million dental-related emergency room visits a year cost $2 billion;[19-22] and

Whereas, California and Massachusetts cut Medicaid dental benefits in 2010 and subsequently saw 32% and 11% increases in dental-related ER visits respectively;[23-24] and

Whereas, California and Massachusetts restored dental benefits in 2014, and Massachusetts saw a 15% reduction in dental-related ER visits afterward;[23-24] and

Whereas, from 2012 to 2014, states that did not expand Medicaid or expanded Medicaid without dental coverage saw a 27% increase in dental-related ER visits, compared to a 14% reduction in states that expanded Medicaid with dental coverage;[25] and

Whereas, AMA advocacy on Medicaid dental coverage does not conflict with the position of the American Dental Association (ADA), which is active on this issue, and amendments to existing AMA policy on working with the ADA on public payer dental benefits to include Medicaid ensures that the AMA would collaborate with and not conflict with the ADA in this area;[26] and

Whereas, to increase savings on emergency and inpatient care costs and overall costs due to lost productivity, reduced employment, and disability, the benefits of Medicaid expansion can be better realized via comprehensive hearing, vision, and dental coverage; therefore be it

RESOLVED, that our AMA-RFS support that routine comprehensive vision exams and visual aids (including eyeglasses and contact lenses) be covered in all Medicaid and CHIP programs and by any other public payers; and be it further

RESOLVED, that our AMA-RFS support that hearing exams, hearing aids, cochlear implants, and aural rehabilitative services be covered in all Medicaid and CHIP programs and any other public payers; and be it further

RESOLVED, that our AMA-RFS support improving access to dental care for Medicare, Medicaid, CHIP, and other public payer beneficiaries

Fiscal Note: Minimal

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RELEVANT RFS POSITION STATEMENTS:

80.009R Medicare Coverage of Dental, Vision, and Hearing Services: That our AMA-RFS support the AMA in supporting new Medicare funding that is independent of the physician fee schedule for coverage of: (1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; and (2) routine eye examinations and visual aids, including eyeglasses; and amending AMA Policy H-185.929 Hearing Aid Coverage to read: 4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team, aural rehabilitative services, and hearing aids as part of Medicare's Benefit. (Resolution 8, I-21)

80.012R Early and Periodic Eye Exams for Adults: , That our AMA-RFS support our AMA in amending policy H-25.990 “Eye Exams for the Elderly” by addition 37 and deletion to read as follows: Eye Exams for the Elderly and Adults H-25.990 Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients and adults who suffer from chronic systemic conditions that increase their likelihood of developing eye disease as well as a baseline eye examination for all adults aged 40 and above; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.

RELEVANT AMA POLICY:

Hearing Aid Coverage H-185.929
1. Our American Medical Association supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.
8. Our AMA supports physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings.
9. Our AMA encourages the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia. [CMS Rep. 6, I-15; Appended: Res. 124, A-19; Appended: CMS Rep. 02, A-23; Reaffirmed: CMS Rep. 02, A-23]

Eye Exams for the Elderly H-25.990
1. Our American Medical Association encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly patients.
2. Our AMA encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. [Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: CMS Rep. 02, A-23]

Medicare Coverage for Dental Services H-330.872
Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. [CMS Rep. 03, A-19; Reaffirmed: CMS Rep. 02, A-23]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 23
(A-24)

Introduced by: Karen Dionesotes, MD, MPH, Sophia Spadafore, MD, Karthik V. Sarma, MD, PhD, Luis Seija, MD, Helene Nepomuceno, MD, Hari Iyer, MD

Subject: Reforming Medicaid Estate Recovery

Referred to: Reference Committee

Whereas, 54% of individuals over the age of 85 will require coverage for paid long term services and supports (LTSS) due to aging or illness, including but not limited to services and supports for activities of daily living, meals, and adult day health care anywhere from months to years, and 5.8 million adults in 2018 required some help with personal or routine activities[1-2] ;and

Whereas, the cost of just one year of LTSS exceeded the median savings for Medicare beneficiaries in 2019, meaning over half of people on Medicare do not have sufficient savings to pay for one year of LTSS;[3] and

Whereas, Because Medicare only covers a limited category of skilled nursing facility care for a specific amount of time and only 11% of individuals over 65 have private coverage for LTSS, many Medicare beneficiaries access such services through Medicaid or unpaid LTSS from their friends, relatives, or community[2-5]; and

Whereas, in order to qualify for Medicaid coverage, individuals must fit into specific state eligibility criteria and income thresholds, generally countable monthly income of no more than the federal benefit rate, which in 2023 is $914 for individuals and $1,317 for couples, meaning Medicare beneficiaries must either have virtually no assets or deplete their savings to receive Medicaid[6-9]; and

Whereas, Title XIX, Section 1917(b)(1)-(3) of the Social Security Act requires states to pursue recovery from the estates of Medicaid beneficiaries who were 55 years or older when they received LTSS, who had long-term care insurance policies under certain circumstances, or who are expected to be permanently institutionalized[4,10]; and

Whereas, state Medicaid estate recovery programs (MERPs) have been justified by the exorbitant cost of LTSS, which in 2020 cost Medicaid over $200 billion and was nearly 5% of all U.S. health expenditures[11]; and

Whereas, despite their promise to recoup the cost of LTSS, state MERPs have had a largely insignificant impact on state budgets, with median recovery of total LTSS expenditures of just 32 0.5% in 2004 and only eight states recovering more than 1.0% and states recovering less than 0.5% in 2019[11-12]; and

Whereas, Title XIX Section 1917(b)(4) of the Social Security Act mandates recovery from “all real and personal property and other assets included within the individual’s estate as defined for purposes of State probate law” but only encourages recovery of nonprobate assets, including

many modern forms of wealth transfer such as joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement[10,13]; and

Whereas, if a state does not adopt an expanded definition of estate that includes nonprobate assets, then it may be unable to recover such assets from MERPs, allowing certain individuals with greater wealth or access to legal services to evade recovery with careful planning[14-15]; and

Whereas, by disproportionately recovering the assets of individuals without access to estate planning services, which largely includes low-income individuals and people of color, MERPs exacerbate racial wealth gaps and prevent intergenerational transfers of wealth[13]; and

Whereas, Black Medicaid beneficiaries 65 years and older die with a median net worth of just $800, while deceased white beneficiaries had a median net worth of $2100, meaning MERPs enforced against black households take significantly larger portions of total assets at death[12]; and

Whereas, the Centers for Medicare and Medicaid Services (CMS) allow states to use Section 1115 waivers to test new approaches to Medicaid than what is currently required by federal statute, and 25 states currently utilize such waivers to provide capitated Medicaid LTSS, which cover hundreds of thousands of beneficiaries[16]; and

Whereas, if a state Medicaid agency wishes to recover the costs of all state health plan services provided to a beneficiary, then it must recover the total capitation payment even if the provides no services to the Medicaid beneficiary, meaning beneficiaries can be liable for services they didn't even receive[17-18]; and

Whereas, given the steep cost of LTSS and the lack of significant recovery by states, the Congressional Budget Office recently released a call for new research on how changes in Medicaid coverage of LTSS would affect the federal budget, signifying the importance of alternative policy[19]; and

Whereas, MERPs are simply one, inefficient and potentially predatory way to finance LTSS, with alternate strategies including models like Community Aging in Place–Advancing Better Living for Elders, which in a demonstration project saved CMS $2,765 per quarter per participant while improving patient outcomes[20]; and

Whereas, in 2017, the state of California drastically limited estate recovery by excluding homes of modest value and the recovery of estates of deceased Medicaid members that are survived by a spouse[21]; and

Whereas, in 2022, the Stop Unfair Medicaid Recoveries Act received more than a dozen bipartisan cosponsors and would have prohibited states from collecting on liens on the estate of Medicaid beneficiaries and required them to withdraw all pending liens;[22] therefore be it

RESOLVED, that our AMA-RFS opposes states to impose liens on or seek adjustment or recovery from the estate of individuals who received long-term services or supports coverage under Medicaid; and be it further

RESOLVED, that our AMA-RFS opposes imposing liens on or seeking adjustment or recovery from the estate of individuals who received long-term services or supports coverage under Medicaid.

Fiscal Note: Minimal

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RELEVANT AMA POLICY:

Policy Directions for the Financing of Long-Term Care H-280.991

The AMA believes that programs to finance long-term care should: (1) assure access to needed services when personal resources are inadequate to finance care; (2) protect personal autonomy and responsibility in the selection of LTC service providers; (3)

prevent impoverishment of the individual or family in the face of extended or catastrophic service costs; (4) cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual; (5) coordinate benefits across different LTC financing program; (6) provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level; (7) provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level; (8) encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased; (9) create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses; and (10) authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to: (a) provide an environment within their states that permit innovative LTC financing and delivery arrangements, and (b) assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high-quality care. The AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. The AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long term care that should not be covered by public or private health care financing mechanisms.

Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing For-Profit Long Term Care Options D-280.982

1. Our AMA will advocate for business models in long term care for the elderly which incentivize and promote the ethical use of resources to maximize care quality, staff and resident safety, and resident quality of life, and which hold patients' interests as paramount over maximizing profit. 2. Our AMA will, in collaboration with other stakeholders, including major payers, advocate for further research into alternatives to current options for long term care to promote the highest quality and value long term care services and supports (LTSS) models as well as functions and structures which best support these models for care. [Res. 023, A-22]