

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2022 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-22)

Report of Reference Committee C

Ramin Manshadi, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

2 RECOMMENDED FOR ADOPTION

3

4 1. Council on Medical Education Report 1 – The Impact of Private Equity on
5 Medical Training

6

7 2. Resolution 304 – Protecting State Medical Licensing Boards from External
8 Political Influence

9

10 RECOMMENDED FOR ADOPTION AS AMENDED

11

12 3. Council on Medical Education Report 2 – Mitigating Demographic and
13 Socioeconomic Inequities in the Residency and Fellowship Selection Process

14

15 4. Resolution 302 – Expanding Employee Leave to Include Miscarriage and
16 Stillbirth

17

18 Resolution 303 – Medical Student Leave Policy

19 Resolution 308 – Paid Family/Medical Leave in Medicine

20

21 5. Resolution 305 – Encouraging Medical Schools to Sponsor Pipeline Programs to
22 Medicine for Underrepresented Groups

23 6. Resolution 306 – Increased Credit for Continuing Medical Education Preparation

24 7. Resolution 309 – Bereavement Leave for Medical Students and Physicians

25 8. Resolution 310 – Enforce AMA Principles on Continuing Board Certification

26 9. Resolution 312 - Reporting of Residency Demographic Data

27 10. Resolution 313 – Request a two-year delay in ACCME Changes to State Medical
28 Society Recognition Program

29 11. Resolution 316 – Recognizing Specialty Certifications for Physicians

1 12. Resolution 317 – Support for GME Training in Reproductive Services
2

3 **RECOMMENDED FOR REAFFIRMATION IN LIEU OF**
4

5 13. Resolution 307 – Fair Compensation of Residents and Fellows
6

7 **RECOMMENDED FOR ADOPTION IN LIEU OF**
8

9 14. Resolution 311 – Supporting a Hybrid Residency and Fellowship Interview
10 Process
11

12 **Amendments: If you wish to propose an amendment to an item of business, click
13 here: [Submit New Amendment](#)**
14

15 Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation
16 Consent Calendar:
17

18 Resolution 314 – Balancing Supply and Demand for Physicians by 2030
19 Resolution 315 – Bedside Nursing and Health Care Staff Shortages

1 RECOMMENDED FOR ADOPTION 2

3 (1) COUNCIL ON MEDICAL EDUCATION REPORT 1 – THE
4 IMPACT OF PRIVATE EQUITY ON MEDICAL TRAINING

5 **RECOMMENDATION:**
6

7 **Recommendations in Council on Medical Education
8 Report 1 be adopted and the remainder of the report be
9 filed.**

10
11 **HOD ACTION: Recommendations in Council on Medical
12 Education Report 1 adopted and the remainder of the
13 report filed**

14
15 That our AMA:

16
17 1. Affirm that an institution or medical education training program academic mission should
18 not be compromised by a clinical training site's fiduciary responsibilities to an external
19 corporate or for-profit entity. (New HOD Policy)

20
21 2. Encourage GME training institutions, programs, and relevant stakeholders to: a.
22 demonstrate transparency on mergers and closures, especially as it relates to private
23 equity acquisition of GME programs and institutions, and demonstrate institutional
24 accountability to their trainees by making this information available to current and
25 prospective trainees;
26 b. uphold comprehensive policies which protect trainees, including those who are not
27 funded by Medicare dollars, to ensure the obligatory transfer of funds after institution
28 closure;
29 c. empower designated institutional officials (DIOs) to be involved in institutional decision-
30 making to advance such transparency and accountability in protection of their residents,
31 fellows, and physician faculty;
32 d. develop educational materials that can help trainees better understand the business of
33 medicine, especially at the practice, institution, and corporate levels;
34 e. develop policies highlighting the procedures and responsibilities of sponsoring
35 institutions regarding the unanticipated catastrophic loss of faculty or clinical training sites
36 and make these policies available to current and prospective GME learners. (Directive to
37 Take Action)

38
39 3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to
40 allow medical students and physicians to enroll in the program even if they receive some
41 or all of their training at a for-profit or governmental institution. (Directive to Take Action)

42
43 4. Support publicly funded independent research on the impact that private equity has on
44 graduate medical education. (New HOD Policy)

45
46

1 5. Encourage physician associations, boards, and societies to draft policy or release their
2 own issue statements on private equity to heighten awareness among the physician
3 community. (Directive to Take Action)

4
5 6. Encourage physicians who are contemplating corporate investor partnerships to
6 consider the ongoing education and welfare for trainee physicians who train under
7 physicians in that practice, including the financial implications of existing funding that is
8 used to support that training. (Directive to Take Action)

9
10 7. Amend Policy D-310.948 "Protection of Resident and Fellow Training in the Case of
11 Hospital or Training Program Closure" by addition to read as follows:
12 Our AMA: (6) will continue to work with ACGME, interested specialty societies, and others
13 to monitor issues, collect data, and share information related to training programs run by
14 corporate and nonprofit entities and their effect on medical education. (Modify HOD Policy)

15
16 8. Reaffirm the following policies:

17
18 • H-310.904 "Graduate Medical Education and the Corporate Practice of Medicine"
19 • H-310.943 "Closing of Residency Programs"
20 • H-310.929 "Principles for Graduate Medical Education"
21 • H-215.981 "Corporate Practice of Medicine" (Reaffirm HOD policy)

22
23 9. Rescind AMA Policy D-310.947 as having been accomplished by this report. (Rescind
24 HOD policy)

25
26 Your Reference Committee reviewed live and online testimony regarding this item.
27 Testimony was received suggesting a title change, in that the report encompasses entities
28 that are beyond private equity, to include United Healthcare, HCA, and Summa. Your
29 Reference Committee considered this point but felt that a title change would have been
30 beyond the intent and the scope of the report. Other testimony expressed strong support
31 for the report, noting how the influence of private equity is far from benign and may cause
32 significant disruptions to the education and training of future physicians as well as harm
33 to underserved communities that rely on safety net hospitals. Therefore, your Reference
34 Committee recommends that CME Report 1 be adopted.

1 (2) RESOLUTION 304 – PROTECTING STATE MEDICAL
2 LICENSING BOARDS FROM EXTERNAL POLITICAL
3 INFLUENCE
4

5 **RECOMMENDATION:**

6 **Resolution 304 be adopted.**

7 **HOD ACTION: Resolution 304 adopted**

8
9
10 RESOLVED, That our American Medical Association work with the Federation of State
11 Medical Boards and other interested parties to minimize external interference with the
12 independent functioning of state medical disciplinary and licensing boards. (Directive to
13 Take Action)
14

15
16 Your Reference Committee reviewed live and online testimony regarding this item.
17 Testimony for this item was largely supportive of the intent yet was mixed between
18 adoption and reaffirmation. Testimony in support of reaffirmation expressed that current
19 policy is broad and already encourages collaboration with other stakeholders. However,
20 there were concerns that current policy does not go far enough to adequately address the
21 present polarized political climate and interference by legislators to limit the ability of the
22 boards to enact their primary mission—that is, protection of the public. References were
23 made regarding current efforts to place licenses in jeopardy for meeting expected
24 standards of care. Therefore, your Reference Committee recommends that Resolution
25 304 be adopted.

1 RECOMMENDED FOR ADOPTION AS AMENDED 2

3 (3) COUNCIL ON MEDICAL EDUCATION REPORT 2 –
4 MITIGATING DEMOGRAPHIC AND SOCIOECONOMIC
5 INEQUITIES IN THE RESIDENCY AND FELLOWSHIP
6 SELECTION PROCESS

7
8 RECOMMENDATION A:

9
10 Recommendation 5 in Council on Medical Education
11 Report 2 be amended by addition, to read as follows:

12
13 5. That our AMA advocate for and support innovation in
14 the undergraduate medical education to graduate
15 medical education transition, especially focusing on
16 the efforts of the Accelerating Change in Medical
17 Education initiative, to include pilot efforts to optimize
18 the residency/fellowship application and matching
19 process and study of the impact of using filters in the
20 Electronic Residency Application Service (ERAS) by
21 program directors on the diversity of entrants into
22 residency. (New HOD Policy)

23
24 RECOMMENDATION B:

25
26 Recommendation 6 in Council on Medical Education
27 Report 2 be amended by addition and deletion, to read
28 as follows:

29
30 6. That our AMA encourage caution among medical
31 schools and residency/fellowship programs when
32 utilizing monitor use of novel online assessments for
33 sampling personal characteristics for the purpose of
34 medical school admissions or residency/fellowship
35 selection and monitor use and validity of these tools
36 and consider their impact on equity and diversity of the
37 physician workforce. (New HOD Policy)

38
39 RECOMMENDATION C:

40
41 Recommendations in Council on Medical Education
42 Report 2 be adopted as amended and the remainder of
43 the report be filed.

44
45 HOD ACTION: Recommendations in Council on Medical
46 Education Report 2 adopted as amended and the remainder
47 of the report filed

1 **Recommendation 5 of Council on Medical Education Report 2**
2 be amended by addition, to read as follows:

3
4 **5. That our AMA advocate for and support innovation in**
5 **the undergraduate medical education to graduate**
6 **medical education transition, especially focusing on**
7 **the efforts of the Accelerating Change in Medical**
8 **Education initiative, to include pilot efforts to optimize**
9 **the residency/fellowship application and matching**
10 **process and encourage the study of the impact of using**
11 **filters in the Electronic Residency Application Service**
12 **(ERAS) by program directors on the diversity of**
13 **entrants into residency. (New HOD Policy)**

14
15 1. That our AMA encourage medical schools, medical honor societies, and
16 residency/fellowship programs to work toward ethical, equitable, and transparent
17 recruiting processes, which are made available to all applicants. (New HOD Policy)
18
19 2. That AMA Policy D-200.985, "Strategies for Enhancing Diversity in the Physician
20 Workforce," be amended by addition and deletion, to read as follows:

21
22 Our AMA will recommend that medical school admissions committees and
23 residency/fellowship programs use holistic assessments of admission applicants
24 that take into account the diversity of preparation and the variety of talents that
25 applicants bring to their education with the goal of improving health care for all
26 communities. (Modify Current HOD Policy)

27
28 3. That our AMA advocate for residency and fellowship programs to avoid using objective
29 criteria available in the Electronic Residency Application Service (ERAS) application
30 process as the sole determinant for deciding which applicants to offer interviews.
31 (Directive to Take Action)
32
33 4. That our AMA advocate to remove membership in medical honor societies as a
34 mandated field of entry on the Electronic Residency Application Service (ERAS)—thereby
35 limiting its use as an automated screening mechanism—and encourage applicants to
36 share this information within other aspects of the ERAS application. (Directive to Take
37 Action)
38
39 5. That our AMA advocate for and support innovation in the undergraduate medical
40 education to graduate medical education transition, especially focusing on the efforts of
41 the Accelerating Change in Medical Education initiative, to include pilot efforts to optimize
42 the residency/fellowship application and matching process. (New HOD Policy)
43
44 6. That our AMA monitor use of novel online assessments for sampling personal
45 characteristics for the purpose of medical school admissions or residency/fellowship
46 selection and consider their impact on equity and diversity of the physician workforce.
47 (New HOD Policy)

1 7. That AMA Policy D-295.963(5), "Continued Support for Diversity in Medical Education,"
2 be rescinded, as having been fulfilled through this report:

4 Our AMA will: ... work with appropriate stakeholders to study reforms to mitigate
5 demographic and socioeconomic inequities in the residency and fellowship selection
6 process, including but not limited to the selection and reporting of honor society
7 membership and the use of standardized tools to rank applicants, with report back to the
8 House of Delegates. (Rescind HOD Policy)

10 Your Reference Committee reviewed online and live testimony regarding this item.
11 Testimony was largely supportive of the recommendations of this well-written and
12 researched report and expressed support for efforts to reaffirm the AMA's commitment to
13 equity. Testimony on Recommendation 4 called for nationwide standardization of the
14 selection process into these honor societies in all medical schools, with a reexamination
15 of the criteria for membership and creation of objectively fair metrics that deal with
16 demographic and socioeconomic inequities in the selection process. Testimony offered
17 the following amendments: opposition to use of online personality assessments,
18 elimination of ERAS filters that could adversely impact international medical graduates,
19 and study of the effect of ERAS filters on equitable admissions. Your Reference
20 Committee believes these amendments go beyond the scope of this report and support
21 future studies to support equitable processes for GME applications. Therefore, your
22 Reference Committee recommends that CME Report 2 be adopted as amended.

23
24 (4) RESOLUTION 302 – EXPANDING EMPLOYEE LEAVE
25 TO INCLUDE MISCARRIAGE AND STILLBIRTH

26
27 RESOLUTION 303 – MEDICAL STUDENT LEAVE
28 POLICY

29
30 RESOLUTION 308 – PAID FAMILY/MEDICAL LEAVE IN
31 MEDICINE

32
33 **RECOMMENDATION A:**

34
35 **Policy H-405.960, "Policies for Parental, Family, and**
36 **Medical Necessity Leave," be amended by addition and**
37 **deletion, to read as follows:**

38
39 **H-405.960, Policies for Parental, Family, and Medical**
40 **Necessity Leave**

41
42 **AMA adopts as policy the following guidelines for, and**
43 **encourages the implementation of, Parental, Family and**
44 **Medical Necessity Leave for Medical Students and**
45 **Physicians:**

1. Our AMA urges ~~medical schools, residency training~~ programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.

2. Recommended components of parental leave policies for ~~medical students and physicians~~ include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.

3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA will study the impact on and feasibility of ~~encourages~~ medical schools, residency programs, specialty boards, and medical group practices to incorporate incorporating into their parental leave policies a ~~six~~¹²-week minimum leave allowance, with the understanding that no parent should 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

1 leave in a 12-month period for their attending and
2 trainee physicians as needed.

3
4 **5. 6.** Residency program directors should review federal
5 and state law for guidance in developing policies for
6 parental, family, and medical leave.

7
8 **6. 7.** Medical students and physicians who are unable to
9 work because of pregnancy, childbirth, abortion or
10 stillbirth, and other related medical conditions should
11 be entitled to such leave and other benefits on the same
12 basis as other physicians who are temporarily unable
13 to work for other medical reasons.

14
15 **7. 8.** Residency programs should develop written
16 policies on ~~parental leave, family leave, and medical~~
17 leave for physicians. Such written policies should
18 include the following elements: (a) leave policy for birth
19 or adoption; (b) duration of leave allowed before and
20 after delivery; **(c) duration of leave allowed after**
21 abortion or stillbirth; **(e)(d)** category of leave credited
22 (e.g., sick, vacation, parental, unpaid leave, short term
23 disability); **(d)(e)** whether leave is paid or unpaid; **(e)(f)**
24 whether provision is made for continuation of
25 insurance benefits during leave and who pays for
26 premiums; **(f)(g)** whether sick leave and vacation time
27 may be accrued from year to year or used in advance;
28 **(g)(h)** extended leave for resident physicians with
29 extraordinary and long-term personal or family medical
30 tragedies for periods of up to one year, without loss of
31 previously accepted residency positions, for
32 devastating conditions such as terminal illness,
33 permanent disability, or complications of pregnancy
34 that threaten maternal or fetal life; **(h)(i)** how time can
35 be made up in order for a resident physician to be
36 considered board eligible; **(i)(j)** what period of leave
37 would result in a resident physician being required to
38 complete an extra or delayed year of training; **(j)(k)**
39 whether time spent in making up a leave will be paid;
40 and **(k)(l)** whether schedule accommodations are
41 allowed, such as reduced hours, no night call, modified
42 rotation schedules, and permanent part-time
43 scheduling.

44
45 **8. 9.** Medical schools should develop written policies on
46 parental leave, family leave, and medical leave for
47 medical students. Such written policies should include
48 the following elements: (a) leave policy for birth or

1 adoption; (b) duration of leave allowed before and after
2 delivery; (c) extended leave for medical students with
3 extraordinary and long-term personal or family medical
4 tragedies, without loss of previously accepted medical
5 school seats, for devastating conditions such as
6 terminal illness, permanent disability, or complications
7 of pregnancy that threaten maternal or fetal life; (d) how
8 time can be made up in order for a medical students to
9 be eligible for graduation with minimal or no delays; (e)
10 what period of leave would result in a medical student
11 being required to complete an extra or delayed year of
12 training; and (f) whether schedule accommodations are
13 allowed, such as modified rotation schedules, no night
14 duties, and flexibility with academic testing schedules.

15
16 8. 10. Our AMA endorses the concept of equal parental
17 leave for birth and adoption as a benefit for resident
18 physicians, medical students, and physicians in
19 practice regardless of gender or gender identity.

20
21 9. 11. Staffing levels and scheduling are encouraged to
22 be flexible enough to allow for coverage without
23 creating intolerable increases in the workloads of other
24 physicians, particularly those in residency programs.

25
26 10. 12. Physicians should be able to return to their
27 practices or training programs after taking parental
28 leave, family leave, or medical leave without the loss of
29 status.

30
31 11. 13. Residency program directors must assist
32 residents in identifying their specific requirements (for
33 example, the number of months to be made up) because
34 of leave for eligibility for board certification and must
35 notify residents on leave if they are in danger of falling
36 below minimal requirements for board eligibility.
37 Program directors must give these residents a
38 complete list of requirements to be completed in order
39 to retain board eligibility.

40
41 12. 14. Our AMA encourages flexibility in residency
42 training programs and medical schools incorporating
43 parental leave and alternative schedules for pregnant
44 trainees house staff.

45
46 13. 15. In order to accommodate leave protected by the
47 federal Family and Medical Leave Act, our AMA
48 encourages all specialties within the American Board of

Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. 16. These policies as above should be freely available online and in writing to all current trainees and applicants to medical school, residency or fellowship. (Modify Current HOD Policy)

RECOMMENDATION B:

Policy H-420.979, "AMA Statement on Family and Medical Leave," be amended by addition, to read as follows:

H-420.979, AMA Statement on Family and Medical 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; 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

1 return from leave, and other factors involved in order to
2 achieve reasonable objectives recognizing the
3 legitimate needs of employees and employers. (Modify
4 Current HOD Policy)

5 **RECOMMENDATION C:**

6 **Amended Policy H-405.960 and H-420.979 be adopted in**
7 **lieu of Resolutions 302, 303, and 308.**

8 **HOD ACTION: Amended Policy H-405.960 and H-**
9 **420.979 adopted in lieu of Resolutions 302, 303, and**
10 **308.**

11 Res 302:

12 RESOLVED, That our American Medical Association amend Policy H-405.960, "Policies
13 for Parental, Family, and Medical Necessity Leave," by addition and deletion to read as
14 follows:

15 Policies for Parental, Family and Medical Necessity Leave H-405.960
16 AMA adopts as policy the following guidelines for, and encourages the implementation of,
17 Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

18 1. Our AMA urges medical schools, residency training programs, medical specialty
19 boards, the Accreditation Council for Graduate Medical Education, and medical group
20 practices to incorporate and/or encourage development of leave policies, including
21 parental, family, and medical leave policies, as part of the physician's standard benefit
22 agreement.

23 2. Recommended components of parental leave policies for medical students and
24 physicians include: (a) duration of leave allowed before and after delivery; (b) category of
25 leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for
26 continuation of insurance benefits during leave, and who pays the premium; (e) whether
27 sick leave and vacation time may be accrued from year to year or used in advance; (f)
28 how much time must be made up in order to be considered board eligible; (g) whether
29 make-up time will be paid; (h) whether schedule accommodations are allowed; and (i)
30 leave policy for adoption; and (j) leave policy for miscarriage or stillbirth.

31 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)
32 residency program directors and group practice administrators should review federal law
33 concerning maternity leave for guidance in developing policies to assure that pregnant
34 physicians are allowed the same sick leave or disability benefits as those physicians who
35 are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough
36 to allow for coverage without creating intolerable increases in other physicians' workloads,
37 particularly in residency programs; and (c) physicians should be able to return to their
38 practices or training programs after taking parental leave without the loss of status.

1 4. Our AMA encourages medical schools, residency programs, specialty boards, and
2 medical group practices to incorporate into their parental leave policies a six-week
3 minimum leave allowance, with the understanding that no parent should be required to
4 take a minimum leave.

5 6. Residency program directors should review federal and state law for guidance in
6 developing policies for parental, family, and medical leave.

7 7. Residency programs should develop written policies on parental leave, family leave,
8 and medical leave for physicians. Such written policies should include the following
9 elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and
10 after delivery; (c) duration of leave allowed after miscarriage or stillbirth; ~~(e)(d)~~ category
11 of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); ~~(d)(e)~~
12 whether leave is paid or unpaid; ~~(e)(f)~~ whether provision is made for continuation of
13 insurance benefits during leave and who pays for premiums; ~~(f)(g)~~ whether sick leave and
14 vacation time may be accrued from year to year or used in advance; ~~(g)(h)~~ extended leave
15 for resident physicians with extraordinary and long-term personal or family medical
16 tragedies for periods of up to one year, without loss of previously accepted residency
17 positions, for devastating conditions such as terminal illness, permanent disability, or
18 complications of pregnancy that threaten maternal or fetal life; ~~(h)(i)~~ how time can be made
19 up in order for a resident physician to be considered board eligible; ~~(i)(j)~~ what period of
20 leave would result in a resident physician being required to complete an extra or delayed
21 year of training; ~~(j)(k)~~ whether time spent in making up a leave will be paid; and ~~(k)(l)~~
22 whether schedule accommodations are allowed, such as reduced hours, no night call,
23 modified rotation schedules, and permanent part-time scheduling.

24 8. Our AMA endorses the concept of equal parental leave for birth, stillbirth, miscarriage,
25 and adoption as a benefit for resident physicians, medical students, and physicians in
26 practice regardless of gender or gender identity.

27 9. Staffing levels and scheduling are encouraged to be flexible enough to allow for
28 coverage without creating intolerable increases in the workloads of other physicians,
29 particularly those in residency programs.

30 10. Physicians should be able to return to their practices or training programs after taking
31 parental leave, family leave, or medical leave without the loss of status.

32 11. Residency program directors must assist residents in identifying their specific
33 requirements (for example, the number of months to be made up) because of leave for
34 eligibility for board certification and must notify residents on leave if they are in danger of
35 falling below minimal requirements for board eligibility. Program directors must give these
36 residents a complete list of requirements to be completed in order to retain board eligibility.

1 12. Our AMA encourages flexibility in residency training programs, incorporating parental
2 leave and alternative schedules for pregnant house staff.

3
4 13. In order to accommodate leave protected by the federal Family and Medical Leave
5 Act, our AMA encourages all specialties within the American Board of Medical Specialties
6 to allow graduating residents to extend training up to 12 weeks after the traditional
7 residency completion date while still maintaining board eligibility in that year.

8
9 14. These policies as above should be freely available online and in writing to all applicants
10 to medical school, residency or fellowship. (Modify Current HOD Policy); and be it further
11 RESOLVED, That due to the prevalence of miscarriage and stillbirth and the need for
12 physical and psychological healing afterwards, our AMA amend Policy H-420.979 "AMA
13 Statement on Family and Medical Leave," by addition to read as follows:

14 AMA Statement on Family and Medical Leave H-420.979

15 Our AMA supports policies that provide employees with reasonable job security and
16 continued availability of health plan benefits in the event leave by an employee becomes
17 necessary due to documented medical conditions. Such policies should provide for
18 reasonable periods of paid or unpaid:

19 (1) medical leave for the employee, including pregnancy; miscarriage, and stillbirth;
20 (2) maternity leave for the employee-mother;
21 (3) leave if medically appropriate to care for a member of the employee's immediate family,
22 i.e., a spouse or children; and
23 (4) leave for adoption or for foster care leading to adoption. Such periods of leave may
24 differ with respect to each of the foregoing classifications, and may vary with reasonable
25 categories of employers. Such policies should encourage voluntary programs by
26 employers and may provide for appropriate legislation (with or without financial assistance
27 from government). Any legislative proposals will be reviewed through the Association's
28 normal legislative process for appropriateness, taking into consideration all elements
29 therein, including classifications of employees and employers, reasons for the leave,
30 periods of leave recognized (whether paid or unpaid), obligations on return from leave,
31 and other factors involved in order to achieve reasonable objectives recognizing the
32 legitimate needs of employees and employers. (Modify Current HOD Policy)

33
34 Res 303:

35
36 RESOLVED, That our American Medical Association amend policy H-405.960 "Policies
37 for Parental, Family and Medical Necessity Leave" by addition and deletion to read as
38 follows:

39
40 Policies for Parental, Family and Medical Necessity Leave, H-405.960

41
42 AMA adopts as policy the following guidelines for, and encourages the implementation of,
43 Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

44
45 1. Our AMA urges ~~medical schools~~, residency training programs, medical specialty
46 boards, the Accreditation Council for Graduate Medical Education, and medical group
47 practices to incorporate and/or encourage development of leave policies, including

1 parental, family, and medical leave policies, as part of the physician's standard benefit
2 agreement.

3
4 2. Recommended components of parental leave policies for ~~medical students and~~ physicians include: (a) duration of leave allowed before and after delivery; (b) category of
5 leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for
6 continuation of insurance benefits during leave, and who pays the premium; (e) whether
7 sick leave and vacation time may be accrued from year to year or used in advance; (f)
8 how much time must be made up in order to be considered board eligible; (g) whether
9 make-up time will be paid; (h) whether schedule accommodations are allowed; and (i)
10 leave policy for adoption.

11
12 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)
13 residency program directors and group practice administrators should review federal law
14 concerning maternity leave for guidance in developing policies to assure that pregnant
15 physicians are allowed the same sick leave or disability benefits as those physicians who
16 are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough
17 to allow for coverage without creating intolerable increases in other physicians' workloads,
18 particularly in residency programs; and (c) physicians should be able to return to their
19 practices or training programs after taking parental leave without the loss of status.

20
21 4. Our AMA encourages medical schools, residency programs, specialty boards, and
22 medical group practices to incorporate into their parental leave policies a six-week
23 minimum leave allowance, with the understanding that no parent should be required to
24 take a minimum leave.

25
26 5. Residency program directors should review federal and state law for guidance in
27 developing policies for parental, family, and medical leave.

28
29 6. Medical students and physicians who are unable to work because of pregnancy,
30 childbirth, and other related medical conditions should be entitled to such leave and other
31 benefits on the same basis as other physicians who are temporarily unable to work for
32 other medical reasons.

33
34 7. Residency programs should develop written policies on parental leave, family leave,
35 and medical leave for physicians. Such written policies should include the following
36 elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and
37 after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave,
38 short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made
39 for continuation of insurance benefits during leave and who pays for premiums; (f) whether
40 sick leave and vacation time may be accrued from year to year or used in advance; (g)
41 extended leave for resident physicians with extraordinary and long-term personal or family
42 medical tragedies for periods of up to one year, without loss of previously accepted
43 residency positions, for devastating conditions such as terminal illness, permanent
44 disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time
45 can be made up in order for a resident physician to be considered board eligible; (i) what
46 period of leave would result in a resident physician being required to complete an extra or
47 delayed year of training; (j) whether time spent in making up a leave will be paid; and (k)

1 whether schedule accommodations are allowed, such as reduced hours, no night call,
2 modified rotation schedules, and permanent part-time scheduling.

3
4 8. Medical schools should develop written policies on parental leave, family leave, and
5 medical leave for medical students. Such written policies should include the following
6 elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and
7 after delivery; (c) extended leave for medical students with extraordinary and long-term
8 personal or family medical tragedies, without loss of previously accepted medical school
9 seats, for devastating conditions such as terminal illness, permanent disability, or
10 complications of pregnancy that threaten maternal or fetal life; (d) how time can be made
11 up in order for a medical students to be eligible for graduation without delays; (e) what
12 period of leave would result in a medical student being required to complete an extra or
13 delayed year of training; and (f) whether schedule accommodations are allowed, such as
14 modified rotation schedules, no night duties, and flexibility with academic testing
15 schedules.

16
17 8. 9.Our AMA endorses the concept of equal parental leave for birth and adoption as a
18 benefit for resident physicians, medical students, and physicians in practice regardless of
19 gender or gender identity.

20
21 9. 10. Staffing levels and scheduling are encouraged to be flexible enough to allow for
22 coverage without creating intolerable increases in the workloads of other physicians,
23 particularly those in residency programs.

24
25 10. 11. Physicians should be able to return to their practices or training programs after
26 taking parental leave, family leave, or medical leave without the loss of status.

27
28 11. 12. Residency program directors must assist residents in identifying their specific
29 requirements (for example, the number of months to be made up) because of leave for
30 eligibility for board certification and must notify residents on leave if they are in danger of
31 falling below minimal requirements for board eligibility. Program directors must give these
32 residents a complete list of requirements to be completed in order to retain board eligibility.

33
34 12. 13. Our AMA encourages flexibility in residency training programs and medical schools
35 incorporating parental leave and alternative schedules for pregnant trainees house staff.

36
37 13. 14. In order to accommodate leave protected by the federal Family and Medical Leave
38 Act, our AMA encourages all specialties within the American Board of Medical Specialties
39 to allow graduating residents to extend training up to 12 weeks after the traditional
40 residency completion date while still maintaining board eligibility in that year.

41
42 14. 15. These policies as above should be freely available online and in writing to all
43 current trainees and applicants to medical school, residency or fellowship. (Modify Current
44 HOD Policy)

1 Res 308:

2
3 RESOLVED, That our American Medical Association policy H-405.960 "Policies for
4 Parental Family and Medical Necessity Leave" be amended by addition and deletion to
5 read as follows:

6
7 AMA adopts as policy the following guidelines for, and encourages the implementation of,
8 Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

9 1. Our AMA urges medical schools, residency training programs, medical specialty
10 boards, the Accreditation Council for Graduate Medical Education, and medical group
11 practices to incorporate and/or encourage development of leave policies, including
12 parental, family, and medical leave policies, as part of the physician's standard benefit
13 agreement.

14 2. Recommended components of parental leave policies for medical students and
15 physicians include: (a) duration of leave allowed before and after delivery; (b) category of
16 leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for
17 continuation of insurance benefits during leave, and who pays the premium; (e) whether
18 sick leave and vacation time may be accrued from year to year or used in advance; (f)
19 how much time must be made up in order to be considered board eligible; (g) whether
20 make-up time will be paid; (h) whether schedule accommodations are allowed; and (i)
21 leave policy for adoption.

22 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)
23 residency program directors and group practice administrators should review federal law
24 concerning maternity leave for guidance in developing policies to assure that pregnant
25 physicians are allowed the same sick leave or disability benefits as those physicians who
26 are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough
27 to allow for coverage without creating intolerable increases in other physicians' workloads,
28 particularly in residency programs; and (c) physicians should be able to return to their
29 practices or training programs after taking parental leave without the loss of status.

30 4. Our AMA encourages medical schools, residency programs, specialty boards, and
31 medical group practices to incorporate into their parental, family, and medical necessity
32 leave policies a six-twelve-week minimum leave allowance, with the understanding that
33 no parent individual should be required to take a minimum leave.

34 5. Our AMA recommends that medical practices, departments and training programs strive
35 to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month
36 period for their attending and trainee physicians as needed.

37 56. Residency program directors should review federal and state law for guidance in
38 developing policies for parental, family, and medical leave.

39 67. Medical students and physicians who are unable to work because of pregnancy,
40 childbirth, and other related medical conditions should be entitled to such leave and other
41 benefits on the same basis as other physicians who are temporarily unable to work for
42 other medical reasons.

43 78. Residency programs should develop written policies on parental leave, family leave,
44 and medical leave for physicians. Such written policies should include the following
45 elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and
46 after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave,
47 short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made
48 for continuation of insurance benefits during leave and who pays for premiums; (f) whether

1 sick leave and vacation time may be accrued from year to year or used in advance; (g)
2 extended leave for resident physicians with extraordinary and long-term personal or family
3 medical tragedies for periods of up to one year, without loss of previously accepted
4 residency positions, for devastating conditions such as terminal illness, permanent
5 disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time
6 can be made up in order for a resident physician to be considered board eligible; (i) what
7 period of leave would result in a resident physician being required to complete an extra or
8 delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether
9 schedule accommodations are allowed, such as reduced hours, no night call,
10 modified rotation schedules, and permanent part-time scheduling.

11 89. Our AMA endorses the concept of equal parental leave for birth and adoption as a
12 benefit for resident physicians, medical students, and physicians in practice regardless of
13 gender or gender identity.

14 910. Staffing levels and scheduling are encouraged to be flexible enough to allow for
15 coverage without creating intolerable increases in the workloads of other physicians,
16 particularly those in residency programs.

17 4011. Physicians should be able to return to their practices or training programs after
18 taking parental leave, family leave, or medical leave without the loss of status.

19 4112. Residency program directors must assist residents in identifying their specific
20 requirements (for example, the number of months to be made up) because of leave for
21 eligibility for board certification and must notify residents on leave if they are in danger of
22 falling below minimal requirements for board eligibility. Program directors must give these
23 residents a complete list of requirements to be completed in order to retain board eligibility.
24 4213. Our AMA encourages flexibility in residency training programs, incorporating
25 parental leave and alternative schedules for pregnant house staff.

26 4314. In order to accommodate leave protected by the federal Family and Medical Leave
27 Act, our AMA encourages all specialties within the American Board of Medical Specialties
28 to allow graduating residents to extend training up to 12 weeks after the traditional
29 residency completion date while still maintaining board eligibility in that year.

30 4415. These policies as above should be freely available online and in writing to all
31 applicants to medical school, residency or fellowship. (Modify Current HOD Policy)

32
33 Your Reference Committee reviewed live and online testimony regarding Resolutions 302,
34 303, and 308. These items were heard separately during the hearing, and are combined
35 here because all three recommend changes to Policy H-405.960 (with 302 also proposing
36 edits to H-420.979). The authors of Resolution 302 testified in strong support of the need
37 to amend current policy to include miscarriage and stillbirth as part of employee leave to
38 allow time for the affected families to heal and cope with these tragic and traumatic
39 experiences. Testimony was received requesting that abortion, the medical terminology
40 for miscarriage, be used in AMA policy. Your Reference Committee concurs with this
41 testimony and has revised the policy throughout, as noted. While acknowledging the
42 sensitivity of the issue, the term abortion is standard medical terminology and therefore
43 your Reference Committee supports its use in AMA policy.

44
45 For Resolution 303, the authors called for a universal leave policy for all medical schools
46 to protect and promote the health of both parent and child. This is particularly of
47 importance as child-bearing years align with career development years, with inevitable
48 conflicts and challenges arising thereof. Testimony was supportive of adoption and offered

1 an amendment to Section 8, subsection D to change the word “without” to “with minimal
2 or no delay.” The Council on Medical Education, meanwhile, expressed its support for
3 substitute language for clause 8, to allow for medical schools to create more generalized
4 and flexible policy that can be tailored to students’ specific situations and in concordance
5 with the institution’s curricular requirements.

6
7 For Resolution 308, testimony was predominately supportive, particularly for the proposed
8 increase in paid parental, family and medical necessity leave from 6 to 12 weeks. The
9 Council on Medical Education recommended that clause 4 of this resolution be studied,
10 given the impacts of leave on competency and medical practice.

11
12 (5) RESOLUTION 305 – ENCOURAGING MEDICAL
13 SCHOOLS TO SPONSOR PIPELINE PROGRAMS TO
14 MEDICINE FOR UNDERREPRESENTED GROUPS

15
16 RECOMMENDATION A:

17
18 The first Resolve of Resolution 305 be amended by
19 addition and deletion, to read as follows:

20
21 RESOLVED, That our American Medical Association
22 urge medical schools to develop or expand the reach of
23 existing pipeline pathway programs for
24 underrepresented middle school, high school and
25 college aged students to motivate them to pursue and
26 prepare them for a career in medicine (New HOD
27 Policy); and be it further

28
29 RECOMMENDATION B:

30
31 The third Resolve of Resolution 305 be amended by
32 addition and deletion, to read as follows:

33
34 RESOLVED, That our AMA recommend that medical
35 school pipeline pathway programs for
36 underrepresented students be free-of-charge or
37 provide financial support with need-based scholarships
38 and grants (New HOD Policy); and be it further

39
40 RECOMMENDATION C:

41
42 Resolution 305 be adopted as amended.

43
44 HOD ACTION: Resolution 305 adopted as amended

45
46 Resolution 305 be amended by addition of a fifth Resolve,
47 to read as follows:

1 **RESOLVED, That our AMA consider quality of K-12**
2 **education a social determinant of health and thus advocate**
3 **for implementation of Policy H-350.979, (1) (a) encouraging**
4 **state and local governments to make quality elementary and**
5 **secondary education available to all.**

6
7 The title of Resolution 305 be amended, to read as follows:
8

9 **ENCOURAGING MEDICAL SCHOOLS TO SPONSOR**
10 **PATHWAY PROGRAMS TO MEDICINE FOR**
11 **UNDERREPRESENTED GROUPS**

12
13 RESOLVED, That our American Medical Association urge medical schools to develop or
14 expand the reach of existing pipeline programs for underrepresented middle school, high
15 school and college aged students to motivate them to pursue and prepare them for a
16 career in medicine (New HOD Policy); and be it further

17
18 RESOLVED, That our AMA encourage collegiate programs to establish criteria by which
19 completion of such programs will secure an interview for admission to the sponsoring
20 medical school (New HOD Policy); and be it further

21
22 RESOLVED, That our AMA recommend that medical school pipeline programs for
23 underrepresented students be free-of-charge or provide financial support with need-based
24 scholarships and grants (New HOD Policy); and be it further

25
26 RESOLVED, That our AMA encourage all physicians to actively participate in programs
27 and mentorship opportunities that help expose underrepresented students to potential
28 careers in medicine. (New HOD Policy)

29
30 Your Reference Committee reviewed live and online testimony regarding this item.
31 Testimony expressed support for both the downstream recommendations made by the
32 authors as well as suggested amendments to incorporate upstream interventions such as
33 encouraging governmental support for quality Kindergarten through 12th grade education
34 as a social determinant of health and as a method to increase the number of qualified
35 applicants to medical school. Your Reference Committee felt that this request was beyond
36 the scope of this proposed policy. A friendly amendment was also offered to update the
37 nomenclature for programs aimed at increasing access to medical education among those
38 who have been historically excluded to “pathway” programs as referenced in an earlier
39 Council on Medical Education Report to demonstrate there are many ways to enter the
40 field of medicine and away from the perspective associated with “pipeline,” a metaphor
41 that implies a rigid and reductionist perspective. This verbiage may also give rise to
42 negative connotations for Native Americans (that is, the all-too-common despoilation of
43 their ancestral lands by pipelines, distended with petroleum and other hazardous
44 substances). Therefore, your Reference Committee recommends that Resolution 305 be
45 adopted as amended.

1 (6) RESOLUTION 306 – INCREASED CREDIT FOR
2 CONTINUING MEDICAL EDUCATION PREPARATION
3

4 **RECOMMENDATION A:**
5

6 **Resolution 306 be amended by addition and deletion, to**
7 **read as follows:**

8 **RESOLVED**, That our American Medical Association,
9 **through its AMA-PRA credit system, collaborate with**
10 **the Accreditation Council on Continuing Medical**
11 **Education (ACCME), to allow physicians to claim an**
12 **amount of Category 1 CME credits that more accurately**
13 **reflects the learning associated with preparing and**
14 **presenting CME programs. Physicians may claim**
15 **minimum of up to four (4) Category 1 CME hours per**
16 **each hour of presentation.** (Directive to Take Action).

17
18 **RECOMMENDATION B:**
19

20 **Resolution 306 be adopted as amended.**

21
22 **HOD ACTION: Resolution 306 adopted as amended**

23
24 **RESOLVED**, That our American Medical Association collaborate with the Accreditation
25 Council on Continuing Medical Education (ACCME), to allow physicians to claim an
26 amount of Category 1 CME credits that more accurately reflects the hours they spend on
27 preparing and presenting CME programs to a maximum of four (4) Category 1 CME hours.
28 (Directive to Take Action)

29
30 Your Reference Committee reviewed live and online testimony regarding this item.
31 Testimony was unanimously supportive of this resolution. Testimony from the Council on
32 Medical Education provided important background information on the claiming of
33 continuing medical education (CME) credit, including the reminder that the number of
34 Category 2 CME credits that can be claimed is not limited, as long as the activity meets
35 the stipulated requirements in the AMA Physician's Recognition Award (AMA PRA)
36 booklet, and that this would be a mechanism for declaring actual hours spent. The Council
37 proffered amendments to in effect double the number of Category 1 credits that could be
38 claimed per hour of time preparing and presenting a CME program. As the owner of the
39 AMA PRA credit system, our AMA is entitled to make this change without the need to
40 collaborate with the Accreditation Council for Continuing Medical Education which was
41 reflected in the Council's additional edit to remove that ask from the resolution. Therefore,
42 your Reference Committee recommends that Resolution 306 be adopted as amended.
43

1 (7) RESOLUTION 309 – BEREAVEMENT LEAVE FOR
2 MEDICAL STUDENTS AND PHYSICIANS

3
4 RECOMMENDATION A:

5
6 Resolution 309 be amended by addition and deletion, to
7 read as follows:

8
9 RESOLVED, That our American Medical Association
10 support bereavement compassionate leave for medical
11 students and physicians:

12
13 1. Our AMA urges medical schools, residency and
14 fellowship training programs, medical specialty boards,
15 the Accreditation Council for Graduate Medical
16 Education, and medical group practices to incorporate
17 and/or encourage development of bereavement
18 compassionate leave policies as part of the physician's
19 standard benefit agreement.

20
21 2. Our AMA will study Recommended components of
22 bereavement compassionate leave policies for medical
23 students and physicians, to include:

24 a. whether cases requiring extensive travel qualify for
25 additional days of leave and, if so, how many days;
26 b. policy and duration of leave for an event impacting
27 pregnancy or fertility including pregnancy loss, an
28 unsuccessful round of intrauterine insemination or of
29 an assisted reproductive technology procedure, a failed
30 adoption arrangement, a failed surrogacy arrangement,
31 or an event that impacts pregnancy or fertility;
32 c. whether leave is paid or unpaid;
33 d. whether obligations and time must be made up; and
34 e. whether make-up time will be paid.

35
36 3. Our AMA encourages medical schools, residency
37 and fellowship programs, specialty boards, specialty
38 societies and medical group practices to incorporate
39 into their bereavement compassionate leave policies a
40 three-day minimum leave, with the understanding that
41 no medical student or physician or medical student
42 should be required to take a minimum leave.

43
44 4. Medical students and physicians who are unable to
45 work beyond the defined bereavement compassionate
46 leave period because of physical or psychological
47 stress, medical complications of pregnancy loss, or
48 another related reason should refer to their institution's

1 sick leave policy, family and medical leave policy, and
2 other benefits on the same basis as other physicians
3 who are temporarily unable to work for other reasons.
4

5 **5. Our AMA supports will study the concept of equal**
6 **bereavement compassionate leave for pregnancy loss**
7 **and other such events impacting fertility in a physician**
8 **or their partner as a benefit for medical students and**
9 **physicians regardless of gender or gender identity.**

10 **6. Staffing levels and scheduling are encouraged to be**
11 **flexible enough to allow for coverage without creating**
12 **intolerable increases in the workloads of other**
13 **physicians, particularly those in residency programs.**

14 **7. These guidelines as above should be freely available**
15 **online and in writing to all applicants to medical school,**
16 **residency, or fellowship. (Directive to Take Action)**

17 **RECOMMENDATION B:**

18 **Resolution 309 be adopted as amended.**

19 **HOD ACTION: Resolution 309 adopted as amended**

20 RESOLVED, That our American Medical Association support bereavement leave for
21 medical students and physicians:

22 1. Our AMA urges medical schools, residency and fellowship training
23 programs, medical specialty boards, the Accreditation Council for
24 Graduate Medical Education, and medical group practices to incorporate and/or
25 encourage development of bereavement leave policies as part of the physician's standard
26 benefit agreement.

27 2. Recommended components of bereavement leave policies for medical students and
28 physicians include:

29 a. whether cases requiring extensive travel qualify for additional days of leave and, if so,
30 how many days;

31 b. policy and duration of leave for an event impacting pregnancy or fertility including
32 pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted
33 reproductive technology procedure, a failed adoption arrangement, a failed surrogacy
34 arrangement, or an event that impacts pregnancy or fertility;

35 c. whether leave is paid or unpaid;

36 d. whether obligations and time must be made up; and

37 e. whether make-up time will be paid.

38 3. Our AMA encourages medical schools, residency and fellowship programs, specialty
39 boards, specialty societies and medical group practices to incorporate into their
40 bereavement leave policies a three-day minimum leave, with the understanding that no
41 physician or medical student should be required to take a minimum leave.

1 4. Medical students and physicians who are unable to work beyond the defined
2 bereavement leave period because of physical or psychological stress, medical
3 complications of pregnancy loss, or another related reason should refer to their institution's
4 sick leave policy, family and medical leave policy, and other benefits on the same basis
5 as other physicians who are temporarily unable to work for other reasons.
6 5. Our AMA supports the concept of equal bereavement leave for pregnancy loss and
7 other such events impacting fertility in a physician or their partner as a benefit for
8 medical students and physicians regardless of gender or gender identity.
9 6. Staffing levels and scheduling are encouraged to be flexible enough to allow for
10 coverage without creating intolerable increases in the workloads of other physicians,
11 particularly those in residency programs.
12 7. These guidelines as above should be freely available online and in writing to all
13 applicants to medical school, residency, or fellowship. (Directive to Take Action)

14
15 Your Reference Committee reviewed live and online testimony regarding this item. While
16 the majority of testimony was supportive, there was sentiment in support of referral, as
17 bereavement is not considered a component of family medical leave. Additionally,
18 testimony expressed concern that "bereavement" could intimate "personhood," with an
19 amendment offered to replace "bereavement" with "compassionate" throughout the
20 resolution, including the title. Your Reference Committee appreciates that the issues
21 associated with this resolution are complex and believes that clauses 2 and 5 of the
22 resolution require a comprehensive review to formulate a comprehensive policy—hence,
23 the recommendation for our AMA to study these issues further. Therefore, your Reference
24 Committee recommends that Resolution 309 be adopted as amended.

25
26 (8) RESOLUTION 310 – ENFORCE AMA PRINCIPLES ON
27 CONTINUING BOARD CERTIFICATION

28
29 **RECOMMENDATION A:**

30
31 Policy H-275.924 be reaffirmed in lieu of the first
32 Resolve of Resolution 310.

33
34 **RECOMMENDATION B:**

35
36 The second Resolve of Resolution 310 be amended by
37 addition and deletion, to read as follows:

38
39 **RESOLVED**, That our AMA continue to publicly report
40 their its work on enforcing AMA Principles on
41 Continuing Board Certification at the Annual and
42 Interim meetings of the AMA House of Delegates.
43 (Directive to Take Action)

44
45 **RECOMMENDATION C:**

46
47 Resolution 310 be adopted as amended.

1 **HOD ACTION: Resolution 310 adopted as amended**

2

3 RESOLVED, That our American Medical Association continue to actively work to enforce
4 current AMA Principles on Continuing Board Certification (Directive to Take Action); and
5 be it further

6

7 RESOLVED, That our AMA publicly report their work on enforcing AMA Principles on
8 Continuing Board Certification at the Annual and Interim meetings of the AMA House of
9 Delegates. (Directive to Take Action)

10

11 Your Reference Committee reviewed live and online testimony regarding this item.
12 Testimony from the Council on Medical Education recommended that AMA policy be
13 reaffirmed in lieu of the first resolve, and that the second resolve be amended to reinforce
14 the value of the AMA's core principles on continuing board certification (CBC) and remove
15 references to timing of a report back. Further testimony was supportive of the Council's
16 recommendations. Your Reference Committee appreciates that the Council will continue
17 to monitor this important subject, as some testimony noted continued concerns about
18 CBC, particularly among specific specialties. Your Reference Committee concurs with the
19 Council's recommendations to the first and second resolves and clarifies that the AMA's
20 core principles on CBC, namely, H-275.924, be reaffirmed in lieu of the first resolve.
21 Therefore, your Reference Committee recommends that Resolution 310 be adopted as
22 amended.

23

24 **Policy recommended for reaffirmation:**

25

26 **H-275.924, "Continuing Board Certification"**

27

28 AMA Principles on Continuing Board Certification

29

30 1. Changes in specialty-board certification requirements for CBC programs should
31 be longitudinally stable in structure, although flexible in content.

32

33 2. Implementation of changes in CBC must be reasonable and take into
34 consideration the time needed to develop the proper CBC structures as well as to
35 educate physician diplomates about the requirements for participation.

36

37 3. Any changes to the CBC process for a given medical specialty board should
38 occur no more frequently than the intervals used by that specialty board for CBC.

39

40 4. Any changes in the CBC process should not result in significantly increased cost
41 or burden to physician participants (such as systems that mandate continuous
42 documentation or require annual milestones).

43

44 5. CBC requirements should not reduce the capacity of the overall physician
45 workforce. It is important to retain a structure of CBC programs that permits
46 physicians to complete modules with temporal flexibility, compatible with their
47 practice responsibilities.

- 1 6. Patient satisfaction programs such as The Consumer Assessment of Healthcare
2 Providers and Systems (CAHPS) patient survey are neither appropriate nor
3 effective survey tools to assess physician competence in many specialties.
4
- 5 7. Careful consideration should be given to the importance of retaining flexibility in
6 pathways for CBC for physicians with careers that combine clinical patient care
7 with significant leadership, administrative, research and teaching responsibilities.
8
- 9 8. Legal ramifications must be examined, and conflicts resolved, prior to data
10 collection and/or displaying any information collected in the process of CBC.
11 Specifically, careful consideration must be given to the types and format of
12 physician-specific data to be publicly released in conjunction with CBC
13 participation.
14
- 15 9. Our AMA affirms the current language regarding continuing medical education
16 (CME): "Each Member Board will document that diplomates are meeting the CME
17 and Self-Assessment requirements for CBC Part II. The content of CME and self-
18 assessment programs receiving credit for CBC will be relevant to advances within
19 the diplomate's scope of practice, and free of commercial bias and direct support
20 from pharmaceutical and device industries. Each diplomate will be required to
21 complete CME credits (AMA PRA Category 1 Credit", American Academy of
22 Family Physicians Prescribed, American College of Obstetricians and
23 Gynecologists, and/or American Osteopathic Association Category 1A)."
24
- 25 10. In relation to CBC Part II, our AMA continues to support and promote the AMA
26 Physician's Recognition Award (PRA) Credit system as one of the three major
27 credit systems that comprise the foundation for continuing medical education in
28 the U.S., including the Performance Improvement CME (PICME) format; and
29 continues to develop relationships and agreements that may lead to standards
30 accepted by all U.S. licensing boards, specialty boards, hospital credentialing
31 bodies and other entities requiring evidence of physician CME.
32
- 33 11. CBC is but one component to promote patient safety and quality. Health care
34 is a team effort, and changes to CBC should not create an unrealistic expectation
35 that lapses in patient safety are primarily failures of individual physicians.
36
- 37 12. CBC should be based on evidence and designed to identify performance gaps
38 and unmet needs, providing direction and guidance for improvement in physician
39 performance and delivery of care.
40 13. The CBC process should be evaluated periodically to measure physician
41 satisfaction, knowledge uptake and intent to maintain or change practice.
42
- 43 14. CBC should be used as a tool for continuous improvement.
44
- 45 15. The CBC program should not be a mandated requirement for licensure,
46 credentialing, recredentialing, privileging, reimbursement, network participation,
47 employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards
2 developing CBC.
17. Our AMA will include early career physicians when nominating individuals to
5 the Boards of Directors for ABMS member boards.
18. CBC activities and measurement should be relevant to clinical practice.
19. The CBC process should be reflective of and consistent with the cost of
10 development and administration of the CBC components, ensure a fair fee
11 structure, and not present a barrier to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be
16 provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured
19 to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek
22 recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board
25 certification recognized by the ABMS related to their participation in CBC.
25. Members of our House of Delegates are encouraged to increase their
28 awareness of and participation in the proposed changes to physician self-
29 regulation through their specialty organizations and other professional
30 membership groups.
26. The initial certification status of time-limited diplomates shall be listed and
33 publicly available on all American Board of Medical Specialties (ABMS) and ABMS
34 Member Boards websites and physician certification databases. The names and
35 initial certification status of time-limited diplomates shall not be removed from
36 ABMS and ABMS Member Boards websites or physician certification databases
37 even if the diplomate chooses not to participate in CBC.
27. Our AMA will continue to work with the national medical specialty societies to
39 advocate for the physicians of America to receive value in the services they
40 purchase for Continuing Board Certification from their specialty boards. Value in
41 CBC should include cost effectiveness with full financial transparency, respect for
42 physicians' time and their patient care commitments, alignment of CBC
43 requirements with other regulator and payer requirements, and adherence to an
44 evidence basis for both CBC content and processes.

1 (9) RESOLUTION 312 – REPORTING OF RESIDENCY
2 DEMOGRAPHIC DATA

3
4 RECOMMENDATION A:

5 The first Resolve of Resolution 312 be amended by
6 addition and deletion, to read as follows:

7
8 RESOLVED, That our American Medical Association
9 work with appropriate stakeholders to encourage that
10 residency programs annually publish and share with
11 FREIDA and other appropriate stakeholders, (a) self-
12 identified and other demographic data, including but
13 not limited to the composition of their program over the
14 last 5 years by age, gender identity, URM historically
15 marginalized, minoritized, or excluded status, sexual
16 orientation and gender identity; and LGBTQIA+ status;
17 (b) parental and family leave policies; and (c) the
18 number and/or proportion of residents who have
19 utilized parental or family leave in the past 5 years
20 (Directive to Take Action); and be it further

21
22 RECOMMENDATION B:

23 The second Resolve of Resolution 312 be amended by
24 deletion, to read as follows:

25 RESOLVED, That our AMA encourage the Accreditation
26 Council for Graduate Medical Education and other
27 relevant stakeholders to annually collect data on
28 pregnancy, childbirth, and parenthood from all
29 accredited US residency programs and publish this
30 data with disaggregation by gender identity and
31 specialty. (New HOD Policy)

32
33 RECOMMENDATION C:

34 Policy H-405.960 be amended by addition, to read as
35 follows:

36 AMA adopts as policy the following guidelines for, and
37 encourages the implementation of, Parental, Family and
38 Medical Necessity Leave for Medical Students and
39 Physicians:

40 1. Our AMA urges medical schools, residency training
41 programs, medical specialty boards, the Accreditation
42 Council for Graduate Medical Education, and medical
43 group practices to incorporate and/or encourage

1 development of leave policies, including parental,
2 family, and medical leave policies, as part of the
3 physician's standard benefit agreement.

4 2. Recommended components of parental leave
5 policies for medical students and physicians include:
6 (a) duration of leave allowed before and after delivery;
7 (b) category of leave credited; (c) whether leave is paid
8 or unpaid; (d) whether provision is made for
9 continuation of insurance benefits during leave, and
10 who pays the premium; (e) whether sick leave and
11 vacation time may be accrued from year to year or used
12 in advance; (f) how much time must be made up in order
13 to be considered board eligible; (g) whether make-up
14 time will be paid; (h) whether schedule
15 accommodations are allowed; and (i) leave policy for
16 adoption.

17 3. AMA policy is expanded to include physicians in
18 practice, reading as follows: (a) residency program
19 directors and group practice administrators should
20 review federal law concerning maternity leave for
21 guidance in developing policies to assure that pregnant
22 physicians are allowed the same sick leave or disability
23 benefits as those physicians who are ill or disabled; (b)
24 staffing levels and scheduling are encouraged to be
25 flexible enough to allow for coverage without creating
26 intolerable increases in other physicians' workloads,
27 particularly in residency programs; and (c) physicians
28 should be able to return to their practices or training
29 programs after taking parental leave without the loss of
30 status.

31 4. Our AMA encourages medical schools, residency
32 programs, specialty boards, and medical group
33 practices to incorporate into their parental leave
34 policies a six-week minimum leave allowance, with the
35 understanding that no parent should be required to take
36 a minimum leave.

37 5. Residency program directors should review federal
38 and state law for guidance in developing policies for
39 parental, family, and medical leave.

40 6. Medical students and physicians who are unable to
41 work because of pregnancy, childbirth, and other
42 related medical conditions should be entitled to such
43 leave and other benefits on the same basis as other
44 physicians who are temporarily unable to work for other
45 medical reasons.

46 7. Residency programs should develop written policies
47 on parental leave, family leave, and medical leave for
48 physicians. Such written policies should include the

1 following elements: (a) leave policy for birth or
2 adoption; (b) duration of leave allowed before and after
3 delivery; (c) category of leave credited (e.g., sick,
4 vacation, parental, unpaid leave, short term disability);
5 (d) whether leave is paid or unpaid; (e) whether
6 provision is made for continuation of insurance
7 benefits during leave and who pays for premiums; (f)
8 whether sick leave and vacation time may be accrued
9 from year to year or used in advance; (g) extended leave
10 for resident physicians with extraordinary and long-
11 term personal or family medical tragedies for periods of
12 up to one year, without loss of previously accepted
13 residency positions, for devastating conditions such as
14 terminal illness, permanent disability, or complications
15 of pregnancy that threaten maternal or fetal life; (h) how
16 time can be made up in order for a resident physician
17 to be considered board eligible; (i) what period of leave
18 would result in a resident physician being required to
19 complete an extra or delayed year of training; (j)
20 whether time spent in making up a leave will be paid;
21 and (k) whether schedule accommodations are allowed,
22 such as reduced hours, no night call, modified rotation
23 schedules, and permanent part-time scheduling.

24 8. Our AMA endorses the concept of equal parental
25 leave for birth and adoption as a benefit for resident
26 physicians, medical students, and physicians in
27 practice regardless of gender or gender identity.

28 9. Staffing levels and scheduling are encouraged to be
29 flexible enough to allow for coverage without creating
30 intolerable increases in the workloads of other
31 physicians, particularly those in residency programs.

32 10. Physicians should be able to return to their
33 practices or training programs after taking parental
34 leave, family leave, or medical leave without the loss of
35 status.

36 11. Residency program directors must assist residents
37 in identifying their specific requirements (for example,
38 the number of months to be made up) because of leave
39 for eligibility for board certification and must notify
40 residents on leave if they are in danger of falling below
41 minimal requirements for board eligibility. Program
42 directors must give these residents a complete list of
43 requirements to be completed in order to retain board
44 eligibility.

45 12. Our AMA encourages flexibility in residency training
46 programs, incorporating parental leave and alternative
47 schedules for pregnant house staff.

1 13. In order to accommodate leave protected by the
2 federal Family and Medical Leave Act, our AMA
3 encourages all specialties within the American Board of
4 Medical Specialties to allow graduating residents to
5 extend training up to 12 weeks after the traditional
6 residency completion date while still maintaining board
7 eligibility in that year.

8 14. These policies as above should be freely available
9 online through FREIDA and in writing to all applicants
10 to medical school, residency or fellowship.

11
12 **RECOMMENDATION D:**

13
14 **Resolution 312 be adopted as amended.**

15
16 **HOD ACTION: Resolution 312 adopted as amended**

17
18 RESOLVED, That our American Medical Association work with appropriate stakeholders
19 to encourage that residency programs annually publish and share with FREIDA and other
20 appropriate stakeholders, (a) demographic data, including but not limited to the
21 composition of their program over the last 5 years by age, gender identity, URM status,
22 and LGBTQIA+ status; (b) parental and family leave policies; and (c) the number and/or
23 proportion of residents who have utilized parental or family leave in the past 5 years
24 (Directive to Take Action); and be it further

25
26 RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical
27 Education and other relevant stakeholders to annually collect data on pregnancy,
28 childbirth, and parenthood from all accredited US residency programs and publish this
29 data with disaggregation by gender identity and specialty. (New HOD Policy)

30
31 Your Reference Committee heard supportive testimony for the intent of this item, which is
32 intended to encourage transparency. The author noted the value in having such data
33 available during the decision-making process, while also acknowledging the importance
34 of protecting privacy. Regarding clause (a) of the first resolve, your Reference Committee
35 discussed the sensitivity of some of the data listed in the first resolve and therefore
36 recommended that "self-identified" be added. Further, your Reference Committee
37 recommended reordering the data points such that "gender identity" and "sexual
38 orientation" are adjacent, and recommended changing "URM" to "historically marginalized,
39 minoritized, or excluded," in keeping with the AMA and AAMC's resource, "Advancing
40 Health Equity: A Guide to Language, Narrative and Concepts." In lieu of clause (b), your
41 Reference Committee recommends that AMA Policy H-405.960 be amended to include
42 "Freida." Your Reference Committee also recommends striking clause (c) due to legal
43 and privacy concerns.

44
45 Regarding the second resolve, your Reference Committee recommends that "pregnancy"
46 be stricken, given the privacy concerns and inappropriate nature of requesting this
47 information. With these revisions, your Reference Committee recommends that
48 Resolution 312 be adopted as amended.

1 (10) RESOLUTION 313 – REQUEST A TWO-YEAR DELAY IN
2 ACCME CHANGES TO STATE MEDICAL SOCIETY
3 RECOGNITION PROGRAM

4
5 **RECOMMENDATION A:**

6
7 **Resolution 313 be amended by addition and deletion, to**
8 **read as follows:**

9
10 **RESOLVED**, That our American Medical Association
11 collaborate with Accreditation Council for Continuing
12 Medical Education (ACCME) ~~with a goal to secure a two-~~
13 ~~year delay in the implementation of any changes to the~~
14 ~~state medical society accreditor program until such~~
15 ~~time that a mutual agreement can be reached~~. During
16 that time, AMA, ACCME and state medical societies will
17 work collaboratively to study the impact and
18 unintended consequences of the proposed action and
19 to create a plan that is in the best interests of all parties,
20 including the continuing medical education providers
21 currently accredited by state medical societies.
22 (Directive to Take Action)

23
24 **RECOMMENDATION B:**

25
26 **Resolution 313 be adopted as amended.**

27
28 **HOD ACTION: Resolution 313 adopted as amended**

29
30 **RESOLVED**, That our American Medical Association collaborate with Accreditation
31 Council for Continuing Medical Education (ACCME) with a goal to secure a two-year delay
32 in the implementation of any changes to the state medical society accreditor program.
33 During that time, AMA, ACCME and state medical societies will work collaboratively to
34 study the impact and unintended consequences of the proposed action and to create a
35 plan that is in the best interests of all parties, including the continuing medical education
36 providers currently accredited by state medical societies. (Directive to Take Action)

37
38 Your Reference Committee reviewed live and online testimony regarding this item. Online
39 testimony from the Accreditation Council for Continuing Medical Education (ACCME)
40 noted that this topic will be addressed as a key agenda item at its annual meeting with the
41 state medical societies next month; therefore, they asked that the AMA not act on this
42 resolution at this time. Further testimony supportive of the resolution expressed several
43 concerns, such as the impact on education in rural areas and in less populous states; the
44 arbitrary nature of the ACCME's proposed changes to the state medical society programs
45 and lack of data linking the number of programs in a given state to the quality of these
46 programs; and an implementation date that does not allow sufficient time for affected
47 states to assess and address the impact of the proposed changes. Testimony expressed
48 urgency to address this matter. Your Reference Committee concurs with the concerns

1 raised and recommends striking "two-year" and adding language requiring mutual
2 agreement among all parties. Therefore, your Reference Committee recommends that
3 Resolution 313 be adopted as amended.
4

5 (11) RESOLUTION 316 – RECOGNIZING SPECIALTY
6 CERTIFICATIONS FOR PHYSICIANS
7

8 **RECOMMENDATION A:**
9

10 The first Resolve of Resolution 316 be amended by
11 addition and deletion, to read as follows:

13 RESOLVED, That our American Medical Association
14 amend Policy H-275.926, "Medical Specialty Board
15 Certification Standards," by addition to read as follows:
16

17 (1) Opposes any action, regardless of intent, that
18 appears likely to confuse the public about the unique
19 credentials of American Board of Medical Specialties
20 (ABMS) or American Osteopathic Association Bureau
21 of Osteopathic Specialists (AOA-BOS) board certified
22 physicians in any medical specialty, or take advantage
23 of the prestige of any medical specialty for purposes
24 contrary to the public good and safety.

25 (2) Opposes any action, regardless of intent, by
26 organizations providing board certification for non-
27 physicians that appears likely to confuse the public
28 about the unique credentials of medical specialty board
29 certification or take advantage of the prestige of
30 medical specialty board certification for purposes
31 contrary to the public good and safety.

32 (3) Continues to work with other medical
33 organizations to educate the profession and the public
34 about the ABMS and AOA-BOS board certification
35 process. It is AMA policy that when the equivalency of
36 board certification must be determined, the certification
37 program must first meet industry accepted standards
38 for certification that include both 1) a process for
39 defining specialty-specific standards for knowledge
40 and skills and 2) offer an independent, external
41 assessment of knowledge and skills for both initial
42 certification and recertification in the medical specialty.
43 In addition, accepted standards, such as those adopted
44 by state medical boards or the Essentials for Approval
45 of Examining Boards in Medical Specialties, will be
46 utilized for that determination.

47 (4) Opposes discrimination against physicians
48 based solely on lack of ABMS or equivalent AOA-BOS

1 board certification, or where board certification is one
2 of the criteria considered for purposes of measuring
3 quality of care, determining eligibility to contract with
4 managed care entities, eligibility to receive hospital
5 staff or other clinical privileges, ascertaining
6 competence to practice medicine, or for other
7 purposes. Our AMA also opposes discrimination that
8 may occur against physicians involved in the board
9 certification process, including those who are in a
10 clinical practice period for the specified minimum
11 period of time that must be completed prior to taking
12 the board certifying examination.

13 (5) Advocates for nomenclature to better
14 distinguish those physicians who are in the board
15 certification pathway from those who are not.

16 (6) Encourages member boards of the ABMS to
17 adopt measures aimed at mitigating the financial
18 burden on residents related to specialty board fees and
19 fee procedures, including shorter preregistration
20 periods, lower fees and easier payment terms. (Modify
21 Current HOD Policy); and be it further

22
23 **RECOMMENDATION B:**
24

25 The second Resolve of Resolution 316 be amended by
26 addition and deletion, to read as follows:

27
28 RESOLVED, that our AMA advocate for federal and
29 state legislatures, federal and state regulators,
30 physician credentialing organizations, hospitals, and
31 other health care stakeholders ~~and the public~~ to define
32 physician board certification as establishing specialty-
33 specific standards for knowledge and skills, using an
34 independent assessment process to determine the
35 acquisition of knowledge and skills for initial
36 certification and recertification. (Directive to Take
37 Action)

38
39 **RECOMMENDATION C:**
40

41 Resolution 316 be adopted as amended.

42 **HOD ACTION: Resolution 316 adopted as amended**

43
44 The first Resolve of Resolution 316 be amended by
45 addition and deletion, to read as follows:

1 RESOLVED, That our American Medical Association
2 amend Policy H-275.926, "Medical Specialty Board
3 Certification Standards," by addition, to read as
4 follows:

5

6 (1) Opposes any action, regardless of intent, that appears
7 likely to confuse the public about the unique credentials
8 of American Board of Medical Specialties (ABMS) or
9 American Osteopathic Association Bureau of
10 Osteopathic Specialists (AOA-BOS) board certified
11 physicians in any medical specialty, or take advantage
12 of the prestige of any medical specialty for purposes
13 contrary to the public good and safety.

14 (2) Opposes any action, regardless of intent, by
15 organizations providing board certification for non-
16 physicians that appears likely to confuse the public
17 about the unique credentials of medical specialty board
18 certification or take advantage of the prestige of
19 medical specialty board certification for purposes
20 contrary to the public good and safety.

21 (3) Continues to work with other medical organizations to
22 educate the profession and the public about the ABMS
23 and AOA-BOS board certification process. It is AMA
24 policy that when the equivalency of board certification
25 must be determined, the certification program must
26 first meet industry accepted standards for certification
27 that include both 1) a process for defining specialty-
28 specific standards for knowledge and skills and 2) offer
29 an independent, external assessment of knowledge and
30 skills for both initial certification and recertification or
31 continuous certification in the medical specialty. In
32 addition, accepted standards, such as those adopted
33 by state medical boards or the Essentials for Approval
34 of Examining Boards in Medical Specialties, will be
35 utilized for that determination.

36 (4) Opposes discrimination against physicians based
37 solely on lack of ABMS or equivalent AOA-BOS board
38 certification, or where board certification is one of the
39 criteria considered for purposes of measuring quality of
40 care, determining eligibility to contract with managed
41 care entities, eligibility to receive hospital staff or other
42 clinical privileges, ascertaining competence to practice
43 medicine, or for other purposes. Our AMA also opposes
44 discrimination that may occur against physicians
45 involved in the board certification process, including
46 those who are in a clinical practice period for the
47 specified minimum period of time that must be

1 completed prior to taking the board certifying
2 examination.
3 (5) Advocates for nomenclature to better distinguish those
4 physicians who are in the board certification pathway
5 from those who are not.
6 (6) Encourages member boards of the ABMS to adopt
7 measures aimed at mitigating the financial burden on
8 residents related to specialty board fees and fee
9 procedures, including shorter preregistration periods,
10 lower fees and easier payment terms. (Modify Current
11 HOD Policy); and be it further

12
13 **The second Resolve of Resolution 316 be referred.**
14

15 RESOLVED, That our American Medical Association amend Policy H-275.926, "Medical
16 Specialty Board Certification Standards," by addition to read as follows:

17 1) Opposes any action, regardless of intent, that appears likely to confuse the public
18 about the unique credentials of American Board of Medical Specialties (ABMS) or
19 American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS)
20 board certified physicians in any medical specialty, or take advantage of the
21 prestige of any medical specialty for purposes contrary to the public good and
22 safety.
23 2) Opposes any action, regardless of intent, by organizations providing board
24 certification for non-physicians that appears likely to confuse the public about the
25 unique credentials of medical specialty board certification or take advantage of the
26 prestige of medical specialty board certification for purposes contrary to the public
27 good and safety.
28 3) Continues to work with other medical organizations to educate the profession and
29 the public about the ABMS and AOA-BOS board certification process. It is AMA
30 policy that when the equivalency of board certification must be determined, the
31 certification program must first meet industry standards for certification that include
32 both 1) a process for defining specialty-specific standards for knowledge and skills
33 and 2) offer an independent, external assessment of knowledge and skills for both
34 initial certification and recertification in the medical specialty. In addition, accepted
35 standards, such as those adopted by state medical boards or the Essentials for
36 Approval of Examining Boards in Medical Specialties, will be utilized for that
37 determination.
38 4) Opposes discrimination against physicians based solely on lack of ABMS or
39 equivalent AOA-BOS board certification, or where board certification is one of the
40 criteria considered for purposes of measuring quality of care, determining eligibility
41 to contract with managed care entities, eligibility to receive hospital staff or other
42 clinical privileges, ascertaining competence to practice medicine, or for other
43 purposes. Our AMA also opposes discrimination that may occur against physicians
44 involved in the board certification process, including those who are in a clinical
45 practice period for the specified minimum period of time that must be completed
46 prior to taking the board certifying examination.
47 5) Advocates for nomenclature to better distinguish those physicians who are in the
48 board certification pathway from those who are not.

1 6) Encourages member boards of the ABMS to adopt measures aimed at mitigating
2 the financial burden on residents related to specialty board fees and fee
3 procedures, including shorter preregistration periods, lower fees and easier
4 payment terms. (Modify Current HOD Policy); and be it further

5
6 RESOLVED, that our AMA advocate for federal and state legislatures, federal and state
7 regulators, physician credentialing organizations, hospitals, other health care
8 stakeholders and the public to define physician board certification as establishing
9 specialty-specific standards for knowledge and skills, using an independent assessment
10 process to determine the acquisition of knowledge and skills for initial certification and
11 recertification. (Directive to Take Action)

12
13 Your Reference Committee reviewed live and online testimony regarding this item. Live
14 testimony expressed support for this resolution and acknowledged the complexities of this
15 issue. Further testimony recommended clarifying that this resolution addresses "initial and
16 continuing certification." In clause (3) of the first resolve, your Reference Committee
17 recommended that the term "industry" be stricken, given its lack of definition, and replaced
18 by "accepted." For the second resolve, testimony from the Council on Medical Education
19 recommended removal of "and the public"; the author concurred with this amendment.
20 Therefore, your Reference Committee recommends that Resolution 316 be adopted as
21 amended.

22
23 (12) RESOLUTION 317 - SUPPORT FOR GME TRAINING IN
24 REPRODUCTIVE SERVICES

25
26 **RECOMMENDATION A:**

27
28 **Resolution 317 be amended by addition and deletion, to**
29 **read as follows:**

30
31 RESOLVED, That AMA policy H-295.923, "Medical Training
32 and Termination of Pregnancy," be amended by addition
33 and deletion, to read as follows:

34
35 **Medical Training and Termination of Pregnancy**

36
37 1. **Our AMA supports the education of medical students,**
38 **residents and young physicians about the need for**
39 **physicians who provide termination of pregnancy**
40 **services, the medical and public health importance of**
41 **access to safe termination of pregnancy, and the**
42 **medical, ethical, legal and psychological principles**
43 **associated with termination of pregnancy.**

44
45 2. **Our AMA supports will advocate for the availability of**
46 **abortion education and hands-on clinical exposure to**
47 **medication and procedural abortion procedures for**
48 **termination of pregnancy, including medication**

1 abortions, for medical students and resident/fellow
2 physicians and opposes efforts to interfere with or
3 restrict the availability of this education and training.
4

5 **3. In the event that medication and procedural abortion**
6 **are limited or illegal in a home institution, our AMA will**
7 **supports pathways for medical students and**
8 **resident/fellow physicians to receive this training at**
9 **another location, including cost subsidization, to**
10 **ensure trainees traveling to another program have**
11 **hands-on training in medication and procedural**
12 **abortion, and will advocate for legal protections for**
13 **both trainees who cross state lines to receive education**
14 **on reproductive health services, including medication**
15 **and procedural abortion, as well as the institutions**
16 **facilitating these opportunities.**
17

18 **4. Our AMA will advocate for funding for institutions**
19 **that provide clinical training on reproductive health**
20 **services, including medication and procedural**
21 **abortion, to medical students and resident/fellow**
22 **physicians from other programs, so that they can**
23 **expand their capacity to accept out-of-state medical**
24 **students and resident/fellow physicians seeking this**
25 **training.**
26

27 **35. Our AMA encourages the Accreditation Council for**
28 **Graduate Medical Education to consistently enforce**
29 **compliance with the standardization of abortion**
30 **training opportunities as per the requirements set forth**
31 **by the relevant Residency Review Committees Review**
32 **Committee for Obstetrics and Gynecology and the**
33 **American College of Obstetricians and Gynecologists'**
34 **recommendations;** and be it further
35

36 **RESOLVED, That our AMA reaffirm policies H-100.948**
37 **"Supporting Access to Mifepristone (Mifeprex)" and H-**
38 **425.969 "Support for Access to Preventive and**
39 **Reproductive Health Services"; and be it further**
40

41 **RECOMMENDATION B:**
42

43 **AMA Policy D-5.999 be amended by addition and**
44 **deletion, to read as follows:**
45

46 **RESOLVED, That AMA Policy D-5.999, "Preserving**
47 **Access to Reproductive Health Services," be amended**
48 **by addition, to read as follows:**

1 Our AMA: (1) recognizes that healthcare, including
2 reproductive health services like contraception and
3 abortion, is a human right; (2) opposes limitations on
4 access to evidence-based reproductive health services,
5 including fertility treatments, contraception, and
6 abortion; (3) will work with interested state medical
7 societies and medical specialty societies to vigorously
8 advocate for broad, equitable access to reproductive
9 health services, including fertility treatments,
10 contraception, and abortion; (4) supports shared
11 decision-making between patients and their physicians
12 regarding reproductive healthcare; (5) opposes any
13 effort to undermine the basic medical principle that
14 clinical assessments, such as viability of the pregnancy
15 and safety of the pregnant person, are determinations
16 to be made only by healthcare professionals with their
17 patients; (6) opposes the imposition of criminal and
18 civil penalties or other retaliatory efforts against
19 patients, patient advocates, physicians, other
20 healthcare workers, and health systems for receiving,
21 assisting in, referring patients to, or providing
22 reproductive health services; (7) will advocate for legal
23 protections for patients who cross state lines to receive
24 reproductive health services, including contraception
25 and abortion, or who receive medications for
26 contraception and abortion from across state lines, and
27 legal protections for those that provide, support, or
28 refer patients to these services; (8) will advocate for
29 legal protections for medical students and physicians
30 who cross state lines to receive education in or deliver
31 reproductive health services, including contraception
32 and abortion, and (89) will review the AMA policy
33 compendium and recommend policies which should be
34 amended or rescinded to reflect these core values, with
35 report back at the 2022 Interim Meeting.

36
37 **RECOMMENDATION C:**

38
39 **Resolution 317 be adopted as amended.**

40
41 **HOD ACTION: Resolution 317 adopted as amended**

42
43 RESOLVED, That AMA policy H-295.923, "Medical Training and Termination of
44 Pregnancy," be amended by addition and deletion to read as follows:
45

46 **Medical Training and Termination of Pregnancy**

47 1. Our AMA supports the education of medical students, residents and young
48 physicians about the need for physicians who provide termination of pregnancy

1 services, the medical and public health importance of access to safe termination
2 of pregnancy, and the medical, ethical, legal and psychological principles
3 associated with termination of pregnancy.

4 2. Our AMA supports will advocate for the availability of abortion education and
5 hands-on exposure to medication and procedural abortion procedures ~~for~~
6 ~~termination of pregnancy, including medication abortions~~, for medical students and
7 resident/fellow physicians and opposes efforts to interfere with or restrict the
8 availability of this education and training.

9 3. In the event that medication and procedural abortion are limited or illegal in a
10 home institution, our AMA supports pathways, including cost subsidization, to
11 ensure trainees traveling to another program have hands-on training in medication
12 and procedural abortion, and will advocate for legal protections for both trainees
13 who cross state lines to receive education on reproductive health services,
14 including medication and procedural abortion, as well as the institutions facilitating
15 these opportunities.

16 34. Our AMA encourages the Accreditation Council for Graduate Medical
17 Education to consistently enforce compliance with the standardization of abortion
18 training opportunities as per the requirements set forth by the relevant Residency
19 Review Committees ~~Review Committee for Obstetrics and Gynecology~~ and the
20 American College of Obstetricians and Gynecologists' recommendations.; and be
21 it further

22
23 RESOLVED, That our AMA reaffirm policies H-100.948 "Supporting Access to
24 Mifepristone (Mifeprex)" and H-425.969 "Support for Access to Preventive and
25 Reproductive Health Services."

26 Your Reference Committee heard live testimony on this item that indicated strong support
27 for the intent of this resolution and the need to support such medical training. Testimony
28 noted great concern regarding lack of training in certain states, given new restrictions and
29 the impact on competency, as the implications could go beyond availability of abortion
30 services. Your Reference Committee reviewed the amendments offered and gave careful
31 consideration to terminology. The Council on Medical Education offered amendments to
32 the second clause of AMA policy H-295.923 including removal of "hands-on"; your
33 Reference Committee agreed with the Council's amendments and recommended
34 replacing "hands-on" with "clinical." For the third and fourth clauses, the Council offered
35 amended language; your Reference Committee concurred and further recommended
36 adding "fellows" after "residents" in the latter part of the sentence, changing "support" to
37 "advocate" to strengthen the ask. In addition, the revised resolution calls for funding to
38 support institutions that provide this training and therefore minimize the costs to the
39 resident and sponsoring institution. Further, your Reference Committee recommended
40 that AMA Policy D-5.999, "Preserving Access to Reproductive Health Services," be
41 amended by the addition of a new clause to advocate for legal protections for medical
42 students and physicians who cross state lines to receive education in or provide
43 reproductive health services, including contraception and abortion. Therefore your
44 Reference Committee recommends that Resolution 317 be adopted as amended.

1 RECOMMENDED FOR REAFFIRMATION IN LIEU OF 2

3 (13) RESOLUTION 307 – FAIR COMPENSATION OF
4 RESIDENTS AND FELLOWS

5
6 **RECOMMENDATION:**
7

8 **Policy H-310.912 and H-305.930 be reaffirmed in lieu of**
9 **Resolution 307.**

10
11 **HOD ACTION: Policy H-310.912 and H-305.930 reaffirmed in**
12 **lieu of Resolution 307**

13
14 RESOLVED, That our American Medical Association advocate for increasing the Resident
15 and Fellow salary substantially (by at least 50% of current levels or better), along with all
16 benefits including retirement benefits with institutional match as available to institutional
17 administration, and peg yearly salary increase thereafter to COLA (Directive to Take
18 Action); and be it further

19
20 RESOLVED, That our AMA advocate for enhanced and uniform payment per resident and
21 fellow for all educational and training institutions across the country (Directive to Take
22 Action); and be it further

23
24 RESOLVED, That our AMA amend the Residents and Fellows Bill of Rights: H-310.912
25 (last modified 2022) accordingly. (Modify Current HOD Policy)

26
27 Your Reference Committee reviewed live and online testimony regarding this item. The
28 author stated that teaching hospitals receive labor at well below market value. Despite
29 significant sentiment for the spirit of the resolution, testimony reflected numerous concerns
30 with its details. For example, the resolution's proposed increase in salaries of 50 percent
31 could have the adverse consequence of lowering the total number of resident/fellow
32 physician slots, with obvious negative implications for the physician workforce. Programs
33 in smaller community hospitals could experience significant negative repercussions, due
34 to insufficient resources and impact on meeting service needs. Other testimony noted
35 concerns with the phrase "uniform payment" in the second resolve, in that the cost of living
36 varies significantly based on geographic location. In response to concerns, the author
37 proposed an amendment to the item, which, serendipitously, is nearly the same as existing
38 Policy H-305.930. Accordingly, your Reference Committee urges reaffirmation of this
39 policy, as well as H-310.912, in lieu of Resolution 307.

40
41 **Policy recommended for reaffirmation:**

42
43 **H-310.912, "Residents and Fellows' Bill of Rights"**

44
45 1. Our AMA continues to advocate for improvements in the ACGME Institutional
46 and Common Program Requirements that support AMA policies as follows: a)
47 adequate financial support for and guaranteed leave to attend professional
48 meetings; b) submission of training verification information to requesting

1 agencies within 30 days of the request; c) adequate compensation with
2 consideration to local cost-of-living factors and years of training, and to include
3 the orientation period; d) health insurance benefits to include dental and vision
4 services; e) paid leave for all purposes (family, educational, vacation, sick) to be
5 no less than six weeks per year; and f) stronger due process guidelines.

6
7 2. Our AMA encourages the ACGME to ensure access to educational programs
8 and curricula as necessary to facilitate a deeper understanding by resident
9 physicians of the US health care system and to increase their communication
10 skills.

11
12 3. Our AMA regularly communicates to residency and fellowship programs and
13 other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

14
15 4. Our AMA: a) will promote residency and fellowship training programs to
16 evaluate their own institution's process for repayment and develop a leaner
17 approach. This includes disbursement of funds by direct deposit as opposed to
18 a paper check and an online system of applying for funds; b) encourages a
19 system of expedited repayment for purchases of \$200 or less (or an equivalent
20 institutional threshold), for example through payment directly from their residency
21 and fellowship programs (in contrast to following traditional workflow for
22 reimbursement); and c) encourages training programs to develop a budget and
23 strategy for planned expenses versus unplanned expenses, where planned
24 expenses should be estimated using historical data, and should include trainee
25 reimbursements for items such as educational materials, attendance at
26 conferences, and entertaining applicants. Payment in advance or within one
27 month of document submission is strongly recommended.

28
29 5. Our AMA will partner with ACGME and other relevant stakeholders to
30 encourage training programs to reduce financial burdens on residents and
31 fellows by providing employee benefits including, but not limited to, on-call meal
32 allowances, transportation support, relocation stipends, and childcare services.

33
34 6. Our AMA will work with the Accreditation Council for Graduate Medical
35 Education (ACGME) and other relevant stakeholders to amend the ACGME
36 Common Program Requirements to allow flexibility in the specialty-specific
37 ACGME program requirements enabling specialties to require salary
38 reimbursement or "protected time" for resident and fellow education by "core
39 faculty," program directors, and assistant/associate program directors.

40
41 7. Our AMA encourages teaching institutions to offer retirement plan options,
42 retirement plan matching, financial advising and personal finance education.

43
44 8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as
45 applicable to all resident and fellow physicians in ACGME-accredited training
46 programs:

1 RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS
2

3 Residents and fellows have a right to:

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

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

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

21 With regard to supervision, residents and fellows must be ultimately supervised
22 by physicians who are adequately qualified and allow them to assume
23 progressive responsibility appropriate to their level of education, competence,
24 and experience. In instances where clinical education is provided by non-
25 physicians, there must be an identified physician supervisor providing indirect
26 supervision, along with mechanisms for reporting inappropriate, non-physician
27 supervision to the training program, sponsoring institution or ACGME as
28 appropriate.

29 C. Regular and timely feedback and evaluation based on valid assessments of
30 resident performance.

31 With regard to evaluation and assessment processes, residents and fellows
32 should expect: (1) Timely and substantive evaluations during each rotation in
33 which their competence is objectively assessed by faculty who have directly
34 supervised their work; (2) To evaluate the faculty and the program confidentially
35 and in writing at least once annually and expect that the training program will
36 address deficiencies revealed by these evaluations in a timely fashion; (3)
37 Access to their training file and to be made aware of the contents of their file on
38 an annual basis; and (4) Training programs to complete primary
39 verification/credentialing forms and recredentialing forms, apply all required
40 signatures to the forms, and then have the forms permanently secured in their
41 educational files at the completion of training or a period of training and, when
42 requested by any organization involved in credentialing process, ensure the
43 submission of those documents to the requesting organization within thirty days
44 of the request.

45 D. A safe and supportive workplace with appropriate facilities.

46 With regard to the workplace, residents and fellows should have access to: (1)
47 A safe workplace that enables them to fulfill their clinical duties and educational
48 obligations; (2) Secure, clean, and comfortable on-call rooms and parking

1 facilities which are secure and well-lit; (3) Opportunities to participate on
2 committees whose actions may affect their education, patient care, workplace,
3 or contract.

4 E. Adequate compensation and benefits that provide for resident well-being and
5 health.

6 (1) With regard to contracts, residents and fellows should receive: a. Information
7 about the interviewing residency or fellowship program including a copy of the
8 currently used contract clearly outlining the conditions for (re)appointment,
9 details of remuneration, specific responsibilities including call obligations, and a
10 detailed protocol for handling any grievance; and b. At least four months advance
11 notice of contract non-renewal and the reason for non-renewal.

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

18 (3) With regard to benefits, residents and fellows must be fully informed of and
19 should receive: a. Quality and affordable comprehensive medical, mental health,
20 dental, and vision care for residents and their families, as well as retirement plan
21 options, professional liability insurance and disability insurance to all residents
22 for disabilities resulting from activities that are part of the educational program;
23 b. An institutional written policy on and education in the signs of excessive
24 fatigue, clinical depression, substance abuse and dependence, and other
25 physician impairment issues; c. Confidential access to mental health and
26 substance abuse services; d. A guaranteed, predetermined amount of paid
27 vacation leave, sick leave, family and medical leave and
28 educational/professional leave during each year in their training program, the
29 total amount of which should not be less than six weeks; e. Leave in compliance
30 with the Family and Medical Leave Act; and f. The conditions under which
31 sleeping quarters, meals and laundry or their equivalent are to be provided.

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

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

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

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

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

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

12
13 9. Our AMA will work with the ACGME and other relevant stakeholders to
14 advocate for ways to defray additional costs related to residency and fellowship
15 training, including essential amenities and/or high cost specialty-specific
16 equipment required to perform clinical duties.

17
18 10. Our AMA believes that healthcare trainee salary, benefits, and overall
19 compensation should, at minimum, reflect length of pre-training education, hours
20 worked, and level of independence and complexity of care allowed by an
21 individual's training program (for example when comparing physicians in training
22 and midlevel providers at equal postgraduate training levels).

23
24 11. The Residents and Fellows' Bill of Rights will be prominently published online
25 on the AMA website and disseminated to residency and fellowship programs.

26
27 12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights
28 online and individually to residency and fellowship training programs and
29 encourage changes to institutional processes that embody these principles.

30
31 **H-305.930, "Residents' Salaries"**

32
33 Our AMA supports appropriate increases in resident salaries.

1 RECOMMENDED FOR ADOPTION IN LIEU OF 2

3 (14) RESOLUTION 311 – SUPPORTING A HYBRID
4 RESIDENCY AND FELLOWSHIP INTERVIEW PROCESS
5

6 RECOMMENDATION:
7

8 Alternate Resolution 311 be adopted in lieu of
9 Resolution 311, to read as follows:

10 **SUPPORT HYBRID INTERVIEW TECHNIQUES FOR**
11 **ENTRY TO GRADUATE MEDICAL EDUCATION**
12

13 **RESOLVED, That our AMA work with relevant**
stakeholders to study the advantages and
disadvantages of an online medical school interview
option for future medical school applicants, including
but not limited to financial implications and potential
solutions, long term success, and well-being of
students and residents (New HOD Policy); and be it
further

22 **RESOLVED, That our AMA encourage appropriate**
stakeholders, such as the Association of American
Medical Colleges, American Association of Colleges of
Osteopathic Medicine, Intealth, and Accreditation
Council for Graduate Medical Education, to study the
feasibility and utility of videoconferencing for graduate
medical education (GME) interviews and examine
interviewee and program perspectives on incorporating
videoconferencing as an adjunct to GME interviews, in
order to guide the development of equitable protocols
for expansion of hybrid GME interviews (Directive to
Take Action).

35 **HOD ACTION: Alternate Resolution 311 adopted in lieu of**
36 **Resolution 311**

39 RESOLVED, That our American Medical Association support incorporating virtual
40 interviews as a component to the residency and fellowship interview process as a means
41 to increase interviewing efficiency (New HOD Policy); and be it further

42 RESOLVED, That our AMA work with appropriate stakeholders, such as the Association
43 of American Medical Colleges and the Accreditation Council for Graduate Medical
44 Education, to study interviewee and program perspectives on incorporating
45 videoconferencing as an adjunct to residency and fellowship interviews, in order to guide
46 the development of protocols for expansion of hybrid residency and fellowship interviews.
47 (Directive to Take Action)

1 Your Reference Committee reviewed live and online testimony regarding this item.
2 Testimony was supportive of the second resolve seeking study. Testimony also favored
3 study of the first resolve, noting that data derived from the study of interviewee and
4 program perspectives, per the second resolve, could help to inform how to best address
5 the first resolve. The Council on Medical Education supported study of both resolves
6 and recommended amendments, offering substitute language for the first resolve to
7 study the advantages and disadvantages of an online medical school interview option
8 for future medical school applicants, and amending the second resolve with clarifying
9 language. The author of the resolution supported the Council's recommendations. In the
10 second resolve, testimony recommended adding the American Association of Colleges
11 of Osteopathic Medicine and Intealth (the parent organization of the Educational
12 Commission for Foreign Medical Graduates) to the relevant stakeholders. Your
13 Reference Committee recommended retitling the resolution for clarity, as the current
14 wording could be misconstrued as a joint process for entry to residency and fellowship.
15 Therefore, your Reference Committee recommends that Resolution 311 be adopted as
16 amended.

1 This concludes the report of Reference Committee C. I would like to thank committee
2 members T. Jann Caison-Sorey, Marygrace Elson, Renato Guerrieri, Heidi Hullinger,
3 Pauline Huynh, and Alex Malter; our AMA team Amber Ryan, Tanya Lopez, Fred Lenhoff,
4 Sanjay Desai, and Richard Pan; and all those who testified before the committee.

T. Jann Caison-Sorey, MD
Michigan

Heidi Hullinger, MD
Orthopaedic Surgery

Marygrace Elson, MD
Obstetrics & Gynecology

Pauline Huynh, MD
California

Renato Guerrieri, MD-PhD student
American College of Physicians

Alex Malter, MD, MPH
Alaska

Ramin Manshadi, MD
California
Chair