Your Reference Committee recommends the following consent calendar for acceptance:

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RECOMMENDED FOR ADOPTION

(1) RESOLUTION 1 – PROHIBITION OF DEATH PENALTY FOR
PERSONS WITH SERIOUS MENTAL ILLNESS

RECOMMENDATION:

Resolution 1 be adopted.

RESOLVED, That our AMA-RFS support that defendants charged with capital crimes should
not be sentenced to death or executed if, at the time of the offense, they had a mental disorder
or disability that significantly impaired their capacity to appreciate the nature, consequences
or wrongfulness of their conduct, to exercise rational judgment in relation to their conduct, or
to conform their conduct to the requirements of the law.

Your Reference Committee heard equal support and opposition to this resolution. Opposition
specifically raised concerns regarding the AMA’s purview of this issue and concerns that it
violated the AMA Code of Ethics (specifically §9.7.3 – Capital Punishment). This section
explains that as a member of a profession dedicated to preserving life when there is hope of
doing so, a physician must not participate in a legally authorized execution. Physician
participation in execution is defined as actions that fall into one or more of the enumerated
categories (a)-(n). Actions that do not constitute physician participation in execution are
enumerated in (o)-(t).

Your Reference Committee consulted with relevant psychiatry experts who provided
additional education regarding the role of forensic psychiatrists in court cases, including
assessing a defendant’s capacity at the time of an alleged crime, and competency to stand
trial. Of note, are §9.7.3(d) which states “…A physician’s medical opinion should be merely
one aspect of the information taken into account by a legal decision maker, such as a judge
or hearing officer” and §9.7.3(o) which states that a physician is not participating in execution
when “testifying as to the prisoner’s medical history and diagnoses or mental state as they
relate to competence to stand trial, testifying as to relevant medical evidence during trial,
testifying as to medical aspects of aggravating or mitigating circumstances during the penalty
phase of a capital case, or testifying as to medical diagnoses as they relate to the legal
assessment of competence for execution.”

As such, capacity and competency evaluations are ultimately determined by a legal decision
maker, not a physician, in deciding whether a defendant should stand trial, be convicted, or is
competent to be executed. Given the importance placed on a physician’s expert opinion in
these evaluations, your Reference Committee does find this within the purview of the AMA
and additionally not in violation of the AMA Code of Ethics. Regarding the ask of the resolution,
we acknowledge that AMA has policy (H-140.896) which states that AMA does not take a
position on capital punishment. However, given that this was written as an internal RFS
position statement, we feel that it is acceptable for RFS to have a record of its divergent belief,
so long as it is the will of the Assembly, and therefore recommend adoption.
RECOMMENDED FOR ADOPTION AS AMENDED

(2) REPORT A – ANALYSIS OF ANTITRUST LEGISLATION REGARDING THE AAMC, ACGME, NRMP, AND OTHER RELEVANT ASSOCIATIONS OR ORGANIZATIONS

RECOMMENDATION A:

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

1. That the following resolved clauses be adopted in lieu of the original resolution:

   a) RESOLVED, That our AMA-RFS support efforts that seek to weaken the antitrust exemption for graduate medical education programs and the MATCH as stated in Section 207 of the Pension Funding Equity Act of 2004, such that evidence of anti-competitive actions against the NRMP be admissible in federal court; and be it further

   b) RESOLVED, That our AMA study with relevant stakeholders alternatives to the current residency and fellowship MATCH process, along with the potential ramifications on physician trainee market value and adherence to federal antitrust laws, which would be less restrictive on free market competition for applicants, to study alternative strategies for resident matching that ensure comparable efficiency and adequate market appreciation for medical residents.

RECOMMENDATION B:

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

RECOMMENDATION

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

1) That the following resolved clauses be adopted in lieu of the original resolution:

   a) RESOLVED, That our AMA-RFS support efforts which seek to weaken the antitrust exemption for graduate medical education programs and the MATCH as stated in
Section 207 of the Pension Funding Equity Act of 2004, such that evidence of anti-competitive actions against the NRMP be admissible in federal court; and be it further
b) RESOLVED, That our AMA study with relevant stakeholders alternatives to the current residency and fellowship MATCH process which would be less restrictive on free market competition for applicants, to study alternative strategies for resident matching that ensure comparable efficiency and adequate market appreciation for medical residents.

Your Reference Committee heard considerable support for the spirit of this Report. Opposition questioned the intent to weaken the antitrust exemption before alternatives have been studied. Further, it questioned the effectiveness of greater free market competition for applicants and advocated for a more general investigation into whether a free-market solution is desirable in the first place.

Your Reference Committee recognizes that this topic is provocative and relevant stakeholders may have concerns about the unintended consequences of the proposed policy. That being said, the first Resolve is written as an internal RFS position statement and will purely serve as a record of the Section’s viewpoints, as we cannot simultaneously petition the AMA to take a policy position while asking it to study whether that position is wise. Should the AMA subsequently study this issue, the RFS may always reintroduce policy resolutions in the future to supplement the findings of the AMA's report.

Furthermore, we recognize that AMA has policy supporting a single Match, but simultaneously recognize the concerns that applicants face with regard to wages, labor, job guarantees, and applicant choice with the current system. We believe that since the AMA is a large stakeholder in this system, it is well-within the purview of the AMA to study the current Match process, alternatives, and their potential implications on trainee market value and antitrust laws prior to taking a formal stance on the subject. Therefore, your Reference Committee recommends that Report A be adopted as amended and the remainder of the report be filed.

(3) RESOLUTION 4 – SUPPORTING THE USE OF RENEWABLE ENERGY IN HEALTHCARE

RECOMMENDATION A:

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

RESOLVED, That our AMA-RFS advocate for disseminate a public statement highlighting the importance of healthcare systems’ timely transition to renewable energy, including wind, solar, geothermal technology, biomass, and hydropower energy; and be it further

RESOLVED, That our AMA-RFS support implementations of policies and incentives that promote the healthcare sector’s transition to renewable energy.
RECOMMENDATION B:

Resolution 4 be **adopted as amended**.

RESOLVED, That our AMA disseminate a public statement highlighting the importance of healthcare systems’ timely transition to renewable energy, including wind, solar, geothermal technology, biomass, and hydropower energy; and be it further

RESOLVED, That our AMA support implementations of policies and incentives that promote the healthcare sector’s transition to renewable energy.

Your Reference Committee heard generally supportive testimony on this resolution. Supporters commended the authors for bringing forth this important issue, considering the breadth of potential legislation that could be raised over the coming years regarding renewable energy. Friendly amendments included asking the AMA to also research the potential application of renewable energy and the transition to renewable energy for the healthcare sector. Given the increased frequency of reports and resolutions surrounding climate change and renewable energy, including but not limited to CSAPH Report 02, “Climate Change and Human Health” being considered at the 2022 Interim Meeting, a Board of Trustees Report to be presented at the 2023 Annual Meeting, and multiple other resolutions, your Reference Committee feels that an internal RFS position statement would allow our RFS delegation to comment on and suggest amendments to resolutions and reports being brought forth as early as this Interim 2022 meeting, and covers an important gap in current RFS position statements. Therefore, your Reference Committee recommends that Resolution 4 be adopted as amended.

(4) **RESOLUTION 6 – SUPPORT FOR GME TRAINING IN REPRODUCTIVE SERVICES**

RECOMMENDATION A:

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

RESOLVED, That AMA policy H-295.923, “Medical Training and Termination of Pregnancy,” be amended by addition and deletion to read as follows:

Medical Training and Termination of Pregnancy
1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA supports will advocate for the availability of abortion education and **hands-on** exposure to medication and procedural abortion procedures for termination of pregnancy, including medication abortions, for medical
students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.

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

34. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the relevant Residency Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists’ recommendations.

and be it further

RECOMMENDATION B:

Resolution 6 be adopted as amended.

RESOLVED, That RFS internal position statement 294.017R, “Academic Freedom,” be amended by addition and deletion to read as follows:

Academic Freedom Access to Medication and Procedural Abortion Training
That our AMA-RFS: (1) support the opportunity for residents to learn medication and procedural for abortion termination of pregnancy; and (2) oppose efforts by other persons, governments, or organizations to interfere with or restrict the availability of training in medication and procedures for abortion termination of pregnancy.; and (3) in the event that medication and procedural abortion are limited or otherwise unavailable at a home institution, supports cost subsidization for trainees traveling out-of-state and/or to another program to have hands-on training in medication and procedural abortion.; and be it further

RESOLVED, That AMA policy H-295.923, “Medical Training and Termination of Pregnancy,” be amended by addition and deletion to read as follows:

Medical Training and Termination of Pregnancy
1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
2. Our AMA supports will advocate for the availability of abortion education and hands-on exposure to medication and procedural abortion procedures for termination of pregnancy, including medication abortions, for medical students and
resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.

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

34. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists’ recommendations.; and be it further

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

RESOLVED, That this resolution be immediately forwarded to the House of Delegates at the November 2022 Interim Meeting.

Your Reference Committee heard overwhelming support for this resolution, especially its timely and relevant implications on physicians in training. A friendly amendment was proposed to promote medication abortion training to all relevant specialties, especially primary care, which the authors supported. We agree that this revised language will strengthen the resolution and support medical trainees seeking out the skills to provide these services in all relevant specialties, including primary care. Therefore, your Reference Committee recommends that Resolution 6 be adopted as amended.
RECOMMENDED FOR ADOPTION IN LIEU OF

(5) RESOLUTION 2 – INCREASING FEMALE REPRESENTATION IN ONCOLOGY CLINICAL TRIALS

RECOMMENDATION A:

Alternate Resolution 2 be adopted in lieu of Resolution 2.

INCREASING MINORITY AND UNDERREPRESENTED GROUP PARTICIPATION IN CLINICAL RESEARCH

RESOLVED, That our AMA amend H-460.911, Increasing Minority Participation in Clinical Research, by addition and deletion to read as follows:

Increasing Minority and Underrepresented Group Participation in Clinical Research H-460.911

1. Our AMA advocates that:
   a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
   b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
   c. Resources be provided to community level agencies that work with those minorities and underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities and underrepresented groups in clinical trials:
   a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders’ support, and listening to community’s needs;
b. Increased outreach to female all physicians to encourage recruitment of minority and female patients from underrepresented groups in clinical trials;
c. Continued minority physician education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients;
d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
e. Fiscal support for minority and underrepresented group recruitment efforts and increasing trial accessibility through optimized patient-centered locations for accessing trials, the ready availability of transportation to and from trial locations, child care services, and transportation, child care, reimbursements, and location.

RECOMMENDATION B:

Alternate Resolution 2 be adopted.

RESOLVED, That our AMA amend H-460.911, Increasing Minority Participation in Clinical Research, by addition and deletion to read as follows:

Increasing Minority and Female Participation in Clinical Research H-460.911

1. Our AMA advocates that:
a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
c. Resources be provided to community level agencies that work with those minorities and females who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Blacks/African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.

2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities and females in clinical trials:
a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders’ support, and listening to community’s needs;
b. Increased outreach to female **all** physicians to encourage recruitment of minority and female patients in clinical trials;

c. Continued minority physician education for **all physicians and physicians-in-training** on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate female and minority subject recruitment and methods for increasing trial accessibility for patients such as community partnerships, optimized patient-centered locations for accessing trials, and the ready availability of transportation to and from trial locations and child care services;

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

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

Your Reference Committee heard generally positive testimony for this resolution. While the AMA has previously promoted inclusion of women in clinical research and studying sex/gender differences in clinical research (policies H-525.988, H-525.991, and D-55.997), disparities remain in practice and there was support for amending this policy to add more inclusive language. Your Reference Committee agrees with these amendments and believes it furthers the goal of advocating for increased female participation while also including those of underrepresented race, sexual orientation, and gender identity without duplicating existing policy. Therefore, your Reference Committee recommends that Alternate Resolution 2 be adopted in lieu of Resolution 2.
RECOMMENDED FOR NOT ADOPTION

(6) RESOLUTION 3 – MEDICATION WASTAGE

RECOMMENDATION:

Resolution 3 not be adopted.

RESOLVED, That our AMA-RFS acknowledge the role of reducing medical wastage in addressing drug shortages; and be it further

RESOLVED, That our AMA support the development and implementation of policies and procedures at a societal and institutional level to reduce the impact of wastage, including by optimizing utilization, while minimizing clinical impact; and be it further

RESOLVED, That our AMA commend ongoing efforts by societies across disciplines in advocating to reduce medical wastage.

Your Reference Committee heard largely supportive testimony on the spirit of this resolution, with concerns raised as to the complexity of the issue and its strong overlap with drug shortages. Existing policy on various ways to mitigate specific forms of medication wastage was cited (H-135.925, H-280.959, D-120.929), as well as the fact that per H-100.956, the Council on Science and Public Health (CSAPH) continues to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers, and reports back at least annually to the House of Delegates on progress made. Since CSAPH is already working on its next drug shortage update, your Reference Committee believes it would be more efficient to task the RFS GC and/or CSAPH Councilor with ensuring medication wastage is addressed in its upcoming report rather than by sending this resolution separately through the HOD. Therefore, your Reference Committee recommends that Resolution 3 not be adopted.
RECOMMENDED FOR REFERRAL FOR DECISION

(7) RESOLUTION 5 – MEDICAL SCHOOL MANAGEMENT OF UNMATCHED MEDICAL STUDENTS

RECOMMENDATION:

Resolution 5 be referred for decision.

RESOLVED, That our AMA convene a task force of appropriate AMA councils, medical education organizations, licensing and credentialing boards, government bodies, impacted communities, and other relevant stakeholders to:

1. Study institutional and systemic factors associated with the unmatched medical graduate status, including, but not limited to:
   a) The GME bottleneck on training positions;
   b) New medical schools and the expansion of medical school class sizes;
   c) Race, geography, income, wealth, primary language, gender, religion, ability, and other structural factors;
   d) Student loan debt;
   e) Predatory business practices by medical schools, loan agencies, private equity, and other groups that prioritize profit over student success rates;
   f) The context, history, and impact of past reports on the state of undergraduate medical education, including the Flexner Report;
   g) The format and variations of institutional and medical organization guidance on best practices to successful matching;

2. Develop best practices for medical schools and medical organizations to support unmatched medical graduates, including, but not limited to:
   a) Tools to identify and remediate students at high risk for not matching into GME programs;
   b) Adequate data on student success rates (e.g., by specialty), and factors associated with success in matching;
   c) Medical school responsibilities to unmatched medical students and graduates;
   d) Outcomes-based tuition relief or reimbursement for unmatched students, wherein, unmatched students are returned some component of their tuition to ease the financial burden of being unable to practice clinical medicine;
   e) Transparent, equity-based solutions to address and ameliorate any inequities identified in the match process;
   f) Alternative, cost-neutral, graduate-level degrees with earlier graduation for students at high risk for not matching (e.g., Master of Medical Sciences);
   g) Career opportunities for unmatched U.S. seniors and US-IMGs, including, but not limited to, a streamlined portal for non-clinical positions, opportunities to transfer accrued educational credits to alternative advanced clinical degrees (e.g., NP or PA programs), and short-term clinical remediation programs with pathways to residency positions; and

3. Require transparency from stakeholders, including medical schools, about any actions taken based on the report of this task force, particularly with regard to the remediation of medical students.
Your Reference Committee heard strong supportive testimony on the spirit of this resolution. Supporters widely acknowledged the financial, emotional, and professional challenges unmatched medical students face and agreed on the need for a study to better identify the root causes and potential solutions. However, it was pointed out by staff that recent data indicates that the number of entry GME positions continues to grow with no signs of a major GME squeeze for US MD and DO seniors. This is supported by the 2022 NRMP Main Residency Match Results (https://www.nrmp.org/match-data-analytics/residency-data-reports/; see Figures 2 and 4). Furthermore, portions of this resolution are already encapsulated by Resolution 209 “Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training” which is already being considered in the HOD at the 2022 Interim Meeting. Finally, the call for a task force will carry a large fiscal note, limiting the viability of this directive. Your Reference Committee agrees that this is an important topic and further study is warranted, however, the modality and specific asks should be identified pending the disposition of Resolution 209. Therefore, your Reference Committee recommends that Resolution 5 be referred for decision.
David Savage, MD, Chair

Peter DeRosa, MD

Karen Dionesotes, MD, MPH

Pauline Huynh, MD

Sophia Spadafore, MD