AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Informational Report: A
(I-23)

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

Subject: Sunset Mechanism (2013)

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

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internal position statements last reviewed from the RFS 2013 fiscal year, as well as other relevant or associated outdated positions.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

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

This information is presented to the Assembly at this November 2023 Interim Meeting in the form of an informational report to allow ample time for delegates to consider these initial recommendations. In order for the sunset mechanism to operate efficiently, it is important that each representative review the report now.

If a delegate disagrees with the recommendation, that delegate will have sufficient time between reading the informational sunset report which is presented to the Assembly and the final report to draft a new resolution. This allows time for new resolutions to be submitted at this meeting to compensate for well-intentioned actions that should be rescinded because they are outmoded. Any new resolution or resolved clauses must stand on its own independent of the sunset report.

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

APPENDIX I
RECOMMENDED ACTIONS ON 2013 RFS POSITIONS

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

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

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

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

	Applicants a Timely Response to Residency Application Outcome	incorporating interview dates increased flexibility, whenever possible, to accommodate applicants' schedules; (2) the ACGME and other accrediting bodies ~~to~~ requir~~e~~ing programs to provide, by electronic or other means, representative contracts to applicants prior to the interview; and (3) residency and fellowship programs informing applicants in a timely manner confirming receipt of their application materials and timely notification of when an applicant is no longer under consideration for an interview. (Resolution 1, I-13) [HOD Resolution 302, A-14]	
281.007R	Student Loan Interest Rates	That our AMA-RFS support legislation aimed at establishing an affordable student loan structure with a variable interest rate capped at no more than 6.8%. (Amended Resolution 3, A-03) (Reaffirmed Report D, I-13) [HOD Resolution 316, A-03]	Reaffirm.
281.022R	Protecting Residents Against Avoidable Financial Constraint Related to Reimbursed Work-Related Expenses	That our AMA-RFS support: (1) training programs evaluating their own institution's process for repayment and develop a leaner approach, including disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; (2) a system of expedited repayment for purchases of $200 or less, for example through payment directly from their programs (in contrast to following traditional workflow for reimbursement); and (3) training programs developing a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants (Payment is strongly recommended in advance but at a minimum, reimbursement should be completed at 2 weeks and not to exceed 1 month after submission of relevant reimbursement documents), and unplanned expenses which includes money spent collective above the planned amount by trainees is strongly recommended to be reimbursed by 1 month after submission of relevant reimbursement documents, with a period not to exceed 6 weeks. (Late Report F, I-	Reaffirm.

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

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

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

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

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

		friendly positions on said issues and continue to educate the general assembly on these issues; (6) That the RFS should continue to work with other resident and fellow based organizations to ensure that the RFS serve as the national spokesperson for all resident and fellow centered issues including student debt, graduate medical education, medical licensure, and resident work hours. In the realm of Membership and Outreach: (7) The RFS and RFS Governing Council should investigate mechanisms to increase retention of members as they transition from one section to another, including: a) members transitioning from the MSS to RFS, b) members transitioning from the RFS to the YPS, and c) members transitioning out of ~~IPM programs~~GME Competency Education Program (GCEP); (8) The RFS should continue to work with the MSS And the YPS to improve mentoring strategies and increase mentoring opportunities such as combined networking events, mentoring panels, combined working groups and specific events targeted by specialty, year, or location; (9~~) The RFS should continue to examine and improve the role of the regions within the RFS, which should include: a) current contact information for region leadership and their contact information available online for access by members; b) the current level of activity in each region and ways to increase involvement; c) the roles and responsibilities of the region leadership; d) novel ways to improve communication, foster leadership and increase membership; e) collaboration with MSS and YPS Sections, including joint region meetings and community service events; (10~~) The RFS Governing Council should work to establish local membership liaisons that will work directly with GME programs to reach out to residency programs and recruit members; (1~~1~~0) The RFS Should continue to work with AMA membership staff to assist with planning local membership recruitment programs and coordinate the involvement of local RFS	

		leaders in said programs; and (1~~2~~1) RFS leaders should continue to encourage Section participants to introduce the Introduction to the Practice of Medicine program to their relevant academic and medical center faculty. In the realm of Communication: (1~~3~~2) The RFS and R~~V~~FS Governing Council should work to establish online social media portals to encourage involvement in RFS activities and increase RFS awareness; (14~~3~~) The RFS Governing Council should investigate methods to ensure there is effective communication with the region leadership on a regular basis; (1~~5~~4) the RFS Governing Council should establish a mechanism to provide Governing Council updates and direct communication to our membership and work with AMA staff to ensure that these updates be disseminated to all RFS members; and (1~~6~~5) The RFS Governing Council should actively work to increase utilization of the RFS listserv and make it available to new members. In general, the RFS Committee on Long Range Planning recommends that: (1~~7~~6) the RFS recommend that a Working Plan be developed by the Committee on Long Range Planning for the RFS Governing Council and approved by the assembly at least every 3 years. (Late Report H, I-13)	
580.017R	AMA-RFS 2013-2016 Working Plan	In the Realm of National Meetings: 1. The RFS Governing Council should work with the AMA to encourage RFS participation in a second business meeting to occur after the annual between meetings and that: a. The RFS should continue to work to ensure that the MSS/RFS research poster symposia continues to be held at a national meeting; b. The RFS Governing Council will continue to work with staff to increase resident and fellow attendance at leadership training events, including the National Advocacy Conference and AMA leadership retreats; 2. The RFS Governing Council should continue to improve the process of election procedures to ensure adequacy, transparency and integrity of the results; 3. The RFS Governing Council should	Rescind. Accidental duplication of 550.008R.

		continue to work to improve content at national meetings that will be relevant to members and that will engage them in the core areas of AMA involvement, Advocacy, Public Health, Community Service, Legislative Policy, Leadership Development and Membership; In the realm of Advocacy: 4. The RFS should continue to make preserving and improving GME funding and addressing future physician workforce issues a key priority of our advocacy actions; 5. The RFS Governing Council should continue to annually identify key issues and mobilize the grassroots network to involve our section in advocating for RFS friendly positions on said issues and continue to educate the general assembly on these issues; 6. That the RFS should continue to work with other resident and fellow based organizations to ensure that the RFS serve as the national spokesperson for all resident and fellow centered issues including student debt, graduate medical education, medical licensure, and resident work hours. In the realm of Membership and Outreach: 7. The RFS and RFS Governing Council should investigate mechanisms to increase retention of members as they transition from one section to another including: a. Members transitioning from MSS to RFS; b. Members transitioning from the RFS to the YPS; c. Members transitioning out of IPM programs; 8. The RFS should continue to work with the MSS and the YPS to improve mentoring strategies and increase mentoring opportunities such as combined networking events, mentoring panels, combined working groups and specific events targeted by specialty, year or location; 9. The RFS should continue to examine and improve the role of the regions within the RFS, which should include: a. Current contact information for region	

		leadership and their contact information available online for access by members; b. The current level of activity in each region and ways to increase involvement; c. The roles and responsibilities of the region leadership; d. Novel ways to improve communication, foster leadership and increase membership; e. Collaboration with MSS and YPS Sections, including joint region meetings and community service events; 10. The RFS Governing Council should work to establish local membership liaisons that will work directly with GME programs to reach out to residency programs and recruit members; 11. The RFS should continue to work with AMA membership staff to assist with planning local membership recruitment programs and coordinate the involvement of local RFS leaders in said programs; 12. RFS leaders should continue to encourage Section participants to introduce the Introduction of the Practice of Medicine program to their relevant academic and medical center faculty; In the realm of Communication: 13. The RFS and RFS Governing Council should work to establish online social media portals to encourage involvement in RFS activities and increase RFS awareness; 14. The RFS Governing Council should investigate methods to ensure there is effective communication with the region leadership on a regular basis; 15. The RFS Governing Council should establish a mechanism to provide Governing Council updates and direct communication to our membership and work with AMA staff to ensure that these updates be disseminated to all RFS members; 16. The RFS Governing Council should actively work to increase utilization of the RFS list-serve and make it available to new members; In general, the Committee recommends that: 17. The RFS recommend that a Working Plan be developed by the Committee on	

		Long Range Planning for the RFS Governing Council and approved by the assembly at least every 3 years. (Late Report H, A-13)	

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Informational Report: B
(I-23)

Introduced by: RFS Governing Council

Prepared by: Ad Hoc IOP Committee

Subject: Internal Operating Procedures Renewal Interim Report

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PURPOSE: This informational report contains the full, unaltered Internal Operating Procedures Renewal report submitted at the RFS A-23 business meeting (Appendix A). The goal of resubmitting this report for consideration is to garner additional comments regarding the changes proposed by last year's Ad Hoc IOP Committee so any changes recommended in the Committee's final report will better reflect the collective will of the Section.

BACKGROUND: The 2022-2023 RFS Ad Hoc IOP Committee was established to revise the RFS IOPs to best serve the evolving needs of the Section. Due to pending reports scheduled for transmission to the AMA House of Delegates that would likely impact the RFS IOPs, a report summarizing the discussions and recommendations of the 2022-2023 Ad Hoc IOP Committee was submitted for comment at A-23 but no changes to the RFS IOPs were passed by the Section at that time. The current 2023-2024 Ad Hoc IOP Committee was therefore convened to further refine the recommendations contained in the 2022-2023 Committee's report as well as to incorporate changes that would address any pending AMA reports' impacts on the RFS IOPs.

COMPOSITION: The following Ad Hoc IOP Committee members were appointed by the Governing Council:

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

CONCLUSION: Your Committee would like to thank the members of the 2022-2023 Ad Hoc IOP Committee as well as all members of the RFS who provided feedback on the Committee's A-23 report. This concludes the Committee's 2023 Interim informational report.

APPENDIX A
PART I

PURPOSE: The Ad Hoc IOP Committee was assembled by the Governing Council to review and revise the AMA-RFS Internal Operating Procedures (IOPs), and to evaluate specific issues related to our IOPs as assigned. These recommendations are to be presented to the RFS General Assembly for discussion and approval, with final language requiring review by the Council of Constitution & Bylaws and the AMA Board of Trustees.

BACKGROUND: The RFS has had a well-documented history of reviewing our internal processes and operations as deemed appropriate. Previous attempts at modernizing and revising the IOPs had taken place in 2016 and 2018. With the changes in our Section's activities and operations during the pandemic, including but not limited to the adaptations to virtual meetings, it was decided that another review of our IOPs would be prudent to update existing procedures, eliminate irrelevant provisions, and propose timely additions. Thus, the 2022-2023 IOP Ad Hoc Committee was formed.

COMPOSITION: The following Ad Hoc IOP Committee members were appointed by the Governing Council:

- Chair: Helene Nepomuceno, MD (previous RFS Chair)
- Vice Chair: Pauline Huynh, MD (previous MSS member of CC&B)
- Membership: Haidn Foster, MD; Victoria Gordon, DO; Patrick Crowley, DO
- GC Liaison: Kieran McAvoy, MD (RFS Chair), James Docherty, DO (RFS Vice Chair)
- CC&B Liaison: Christopher Libby, MD

TIMELINE:

August, September	Committee members completed independent review of assigned sections and submitted draft language
September, October	First progress report with redlined changes shared to Governing Council, who will shared proposed final language to RFS for commentary
November	First progress report uploaded to the Virtual Reference Committee (VRC) for member commentary
December, January	The Governing Council convened to review and discuss proposed language. The Committee is asked to evaluate the issue of leadership opportunities within the RFS.
February	Committee members convened to discuss the issue of leadership within the RFS and to review feedback from the Governing Council. The second progress report was adapted accordingly.
March	The second redlined IOP progress report is uploaded for RFS member comment during an open period. Following this comment period, Committee

	members along with the resident member of the CC&B convened to review feedback and discuss further changes to the IOP report.
May	The final rendition of the IOP report is uploaded on the VRC.

CORE AREAS OF DISCUSSION: Your Committee convened in between asynchronous working sessions to review and discuss any pertinent issues brought forth that were thought to be related to our IOPs, which included the following (in no particular order):

Reprioritizing the Mission of the RFS
Your Committee reviewed and reorganized the major tenets pertaining to the Section's mission to center our members' experiences, values, and engagement as our top priority (II.B).

Clarifying Membership & Involvement within the RFS
Your Committee reviewed a couple of interconnected issues pertaining to membership with the Section (III.A).

Firstly, your Committee has received requests to provide additional clarification within the IOPs to address the ambiguities that exist in AMA Bylaw 7.1.1, including the absence of a set definition for "primary occupation" as a resident or fellow that would define membership eligibility in the RFS. In discussion with the resident member on CC&B, the Committee confirmed that any changes to membership eligibility would require a change to the AMA Bylaws, as membership is already defined by Bylaw 7.1.1; that is, revisions to the RFS IOPs to provide any such clarification would not supercede the bylaws as written. Your Committee did briefly discuss the merits of proposing a Bylaws Change; however, this was ultimately not pursued as a recommendation due to limited information on the sentiment of the broader membership e.g.) How much of our Section sees this as a critical issue?) and concern for unintended consequences once this section of the bylaws becomes subject to House debate. Thus, your Committee did not propose any additional changes to Section III.A, and recommends that your Governing Council host an Open Forum to discuss this and other related issues to ascertain the sentiment of the Section.

Related to the issue of membership eligibility, your Committee also reviewed the scenario of when a member graduates from the RFS and enters the YPS, and then returns for additional training. Upon further review of Bylaws 7.1.1 and 7.5.1 and in consultation with pertinent parties, including CC&B and our AMA Membership division, your Committee confirms that such members may rejoin the RFS with full rights and opportunities associated with membership. Membership between RFS and YPS are mutually exclusive. As mentioned above, given that this eligibility is defined by the AMA Bylaws, your Committee did not feel that revisions to the IOPs were necessary.

Leadership Opportunity within the RFS: Your Committee reviewed a number of issues related to leadership opportunities within the Section, from organizational structure, specific positions and vacancies, and eligibility to pursue these leadership opportunities.

Removing Language on RFS Regions. Your Committee recommended the deletion of Section XII and V.G.4, as the Regions system of leadership has not been employed within the RFS since 2020 due to the COVID-19 pandemic with resultant virtual meetings and no allocated time for regional activities or caucusing. Moreover, in consultation with your RFS Governing Council,

the Committee learned that even prior to COVID-19 pandemic, locoregional meetings and events were scarce, and elected regional leaders served primarily to liaison between the Governing Council and its membership. Furthermore, even with the recent resumption of RFS Business Meetings, there has not been a need or vocalized desire to bring back Regional Caucuses, thereby supporting the notion that the system has been obsolete and can be removed from the IOPs.

Streamlining the Standing Committees. Your Committee streamlined XI.A and XI.E to remove language pertaining to specific committees. The aim of this recommendation was to allow for flexibility in the creation and modification of existing Standing Committees as appropriate to best suit the interests of the Section. This recommendation received mixed feedback on the open forum, with some parties approving the additional flexibility, while others cited some concern regarding loss of institutional memory. However, your Committee notes, and your Governing Council confirms, that Standing Committee descriptions are shared on the AMA-RFS webpage, on leadership applications sent on a semi-annual basis, and are passed down within the membership. Furthermore, by removing specific Committee descriptions from the IOPs, this eliminates the need for regular IOP changes with each new creation of modification of a Standing Committee.

Your committee also received concern regarding the proposed change to XI.B, modifying the appointments from an annual to semi-annual basis. The intention of this change was to both allow for the appointment of interim members for 6-month terms and as well as allow the transition of the Vice Chair/Chair-Elect to Chair position within the Standing Committee during the last 6 months of the appointment. However, your Committee acknowledges the confusion and agrees that codifying that transition may be overly prescriptive. Thus, language was clarified in this rendition of the report.

Vacancies and Substitutions among the Sectional Delegates. Your Committee received feedback during the open comment period to review the process for substitutions and vacancies among the Sectional Delegates and Alternate Delegates. Specifically, there was concern regarding the vacancies caused by members who are elected but fail to complete their entire term (as defined by VIII.F), often due to graduating and ceasing to meet the Section's membership requirements. IOP VIII.G addresses the purview of the RFS Delegate and Alternate Delegate to fill vacancies through temporary appointments as appropriate. Your Committee reached out to the Governing Council to see how this has played out in practice. For this past year, anticipated vacancies were identified and utilized Sectional Delegate election results from Interim 2022 results to make their appointments, with Alternate Delegates being promoted to fill Sectional Delegate vacancies, and appointments were made from RFS members who participated in the 2022 results to fill these new Alternate Delegate vacancies.

While your Committee acknowledges the concern that such appointments may be viewed "undemocratic", delegation rosters for the year are submitted prior to the Annual House of Delegates, as established by the AMA Bylaws, and the process is standardized across House constituent sections, states, and specialty organizations. Moreover, promoting Sectional Alternate Delegates to fulfill vacant Sectional Delegate positions would appear appropriate (VIII.G.1.) Furthermore, your Committees weighed the benefits and consequences of codifying any specifications in the IOPs, whereby subsequent revisions warrant approval not only by the Section but also the CCB and our AMA Board of Trustees, . Thus, your Committee opted not to recommend any concrete revision to these IOPs to maintain the flexibility our system in ensuring that our delegation can fill vacancies as allowed in our AMA Bylaws; instead, your Committee recommends that the RFS Governing Council create and disseminate an RFS

Elections & Endorsements Document to the Section outlining candidate endorsements, disclosures (including anticipated failure to complete the full term), and guidelines regarding how election results may to be utilized to fill anticipated vacancies over the coming year, in line with Section V.G.

Addressing Possible Vacancy for RFS Trustee. Your Committee received a request to modify IOP VI.D due concern regarding lack of resident and fellow representation on the Board of Trustee should this position become vacant. After consulting your resident member on CC&B, the Committee confirms that this issue cannot be addressed through an IOP revision. This is because the Resident/Fellow Physician Trustee may be *endorsed* by the RFS, but is ultimately elected by the House of Delegates per Bylaw 3.4.2.2. Thus, any proposals to change this IOP would necessitate a change to Bylaw 3.5.5; given limited feedback from the broader RFS membership on this proposal, your Committee did not find it prudent to proceed.

Restricting Eligibility for RFS Leadership Positions. As part of this review, your Committee also discussed the specific issue of eligibility for RFS leadership opportunities. Currently, any resident or fellow, as defined by AMA Bylaw 7.1.1 with their residency or fellowship being their "primary occupation", is eligible to serve within RFS leadership or RFS-designated positions. In recent years, there have been concerns regarding the utility of additional leadership "caps" to ensure more equitable opportunity among the membership. Your Committee unanimously agreed that such caps would be arbitrary and unnecessary outside of the term limits already delineated in the IOPs, especially as these additional caps would inadvertently penalize members who did not get involved in the RFS until later in their training or would not qualify for leadership opportunities elsewhere outside of the RFS. Furthermore, your Committee believes that the RFS Assembly and membership should be able to self-regulate when deciding between diversity over experience in leadership. Given its tie-in with the issue of membership as noted earlier in this report, your Committee recommends that the RFS Governing Council host an Open Forum to solicit member comment on these issues.

Tenure on the RFS Governing Council. Your Committee recommended modification to IOP IV.F to further streamline the language, but realize that this may have caused confusion and the perception that the change extends leadership tenure within the Governing Council. This is not the case. As originally written, there were a number of exceptions that, if utilized, would allow a member of the RFS to serve on the Governing Council for up to 4 years through the following scenario:

- Scenario A: one term as At-Large Officer, followed by one term as Vice Speaker or Alternate Delegate, then two one-year terms as Speaker or Delegate (old IOP IV.F.3.b-c), for a total of 4 years
- Scenario B: one term as Vice Speaker, then one term as Speaker, then one two-term as Chair-Elect/Chair/Immediate Past year (old IOP IV.F.3.a), for a total of 4 years

The proposed revision thus aims to only streamline the language without extending the tenure in practice.

<u>RFS Business & Elections:</u> Your Committee streamlined language pertaining to elections, including the use of election paraphernalia and promotion of electronic alternatives (V.D.1). Language was also broadened to accommodate virtual elections as has been conducted since 2020 (IX.E).

Your Committee received feedback regarding the issue of personal endorsements from members of the Governing Council. The initial recommendation to strike V.D.1.f.6 was intended

to portray that neither professional nor personal endorsements should be condoned. The overall language of V.D.1.f was further revised to provide this clarification.

Lastly, your Committee proposed a change to IX.D.2.b(3) to allow the involvement of national organizations consisting *primarily* of residents and fellows rather than *solely* of residents and fellows. There was concern about this change leading to a slippery slope in regards to who may apply for representation and involvement during the RFS Assembly Meetings. First, your Committee would like to clarify that this clause of the IOPs only pertains to organizations that do not already have a seat within the AMA House of Delegates. Secondly, the Committee has confirmed with the Governing Council and resident member of CC&B that there are a number of stopgaps in place, and that any additional applications from organizations ultimately require approval from the RFS Governing Council and the AMA Board of Trustees.

CONCLUSION: Your Committee would like to thank the members who provided their feedback to our reports and recommendations over the past year, as well as to our Governing Council and CC&B members who served as references as the Committee conducted its review. This concludes the summary of the major Committee discussions.

Part II

American Medical Association Resident and Fellow Section

Internal Operating Procedures*

I. Name

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

II. Mission

A. Mission of the Sections. AMA Bylaw 7.0.1 defines the mission of the AMA Sections.

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

1. Ensures that residents and fellows are treated fairly, regardless of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, or age and given the full opportunity to engage in, and be represented by, the AMA.

2. Provides a forum to discuss issues and establish policies of importance to residents and fellows including, but not limited to, graduate medical education.

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

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

~~2.~~5. ~~Ensures that residents and fellows are treated fairly, regardless of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, or age and given the full opportunity to receive graduate medical education within the policy-making structure of the AMA.~~

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

~~4.~~6. ~~Provides a forum to discuss timely and controversial issues, identify solutions, and cultivate relationships with residents and fellows.~~

III. Membership

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

IV. Governing Council

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

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

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

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

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

Time commitments. Governing Council members are expected to participate to the fullest extent possible in the activities of the Council and the Section. Governing Council members should be prepared to commit to attending through the RFS Assembly at ~~up to two days each for~~ the Annual and Interim meetings, with the exception of the Delegate and Alternate Delegate whose commitment will be for the entire ~~up to seven~~

~~days for the~~ Annual Meeting and ~~six days for the~~ Interim Meeting, including the House of Delegates portion of the meeting. Governing Council members should also be prepared to commit to ~~three in person Council meetings, plus two hours per month, on average, for~~ conference calls and other meetings as required for the business of the Section.

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

2. Vice Chair. The Vice~~-~~ Chair shall:
   a) Coordinate internal operations of the RFS standing committees and communication with RFS members representing the Section in external capacities.
   b) Preside at meetings of the Governing Council in the absence of the Chair or at the discretion of the Chair.
   c) Assist the Chair in the performance of their duties.

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

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

5. Speaker. The Speaker shall:

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

6. Vice Speaker. The Vice Speaker shall:
a) Preside at Business Meetings during the absence of or at the request of the Speaker.
b) Assist the Speaker in the performance of their duties.
c) ~~Coordinate the AMA-RFS Research Symposium.~~

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

7. Chair-Elect. The Chair-Elect shall:
a) Assist the Governing Council in the discharge of their duties.
b) Compose an agenda for their year of service prior to assuming the position of Chair, with the assistance of the current Chair.
c) Be an ex officio, non-voting member of the Governing Council.

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

F. Terms.

1. Governing Council members shall serve one-year terms, beginning at the conclusion of the Annual meeting at which they were elected and ending at the conclusion of the next Annual meeting of the AMA.

1. This provision shall not be applicable to the Chair, whose term will be two years, including six months as Chair-Elect and six months as Immediate Past Chair.
~~1.~~2. The Immediate-Past Chair may be an immediate past graduate of the RFS.

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

~~3.~~ Tenure. Members are limited to two terms per position, up to a maximum of four total years, consecutive or nonconsecutive, ~~two one-year terms~~ on the Governing Council, with the ~~following~~ exceptions of the Chair-Elect/Chair/Immediate-Past Chair, who shall be restricted to one Chair term as defined by E.1.1.~~:~~
~~a) Chair-Elect/Chair/Immediate Past Chair: may serve up to two previous one-year terms before election to Chair-Elect~~
~~b) Delegate: may serve two terms as Delegate, consecutive or nonconsecutive, in addition to two other one-year terms~~
~~c)~~3. ~~Speaker: may serve two terms as Speaker, consecutive or nonconsecutive, in addition to two other one-year terms~~.
~~d)~~a) The limits shall be waived should their enforcement result in a position being left vacant.

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

G. Vacancies. Any vacancy occurring on the Governing Council shall be filled at the next Business Meeting of the Resident and Fellow Section. The new members shall be elected for the remainder of the unexpired term by the representatives to the Business Meeting.

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

V. Elections & Endorsements

A. Time of Election & Endorsements.

1. The following elections shall be held at the RFS Interim Business Meeting:
   a) Governing Council: Chair-Elect.

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b) Sectional Delegates and Sectional Alternate Delegates.
c) Endorsements for elections at next Annual meeting including RFS position on the Board of Trustees and RFS position on elected AMA Councils.

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

3. The Governing Council shall set the timeframe of the elections and endorsements.

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

C. Eligibility.

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

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

D. Campaigns.

1. Each candidate shall observe the following Campaign Rules:
   a) Candidates may not distribute physical~~only the following~~ campaign materials, including but not limited to: buttons,

stickers, pins, business cards, trinkets, posters, candy, pens, or other items:

~~(1) Buttons (less than 2 inches in greatest dimension).~~
~~(2) Stickers.~~
~~(3) Pins.~~
~~(4) Standard-size business cards.~~
~~(5)~~(1) ~~No trinkets, posters, candy, pens, or other items may be displayed or distributed.~~

b) Candidates shall follow application requirements and restrictions included in the nomination packet.

c) Candidates should be prudent and courteous regarding the number and content of advance mailings by themselves or constituent associations, specialty organizations, or other organizations on their behalf.

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

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

f) Neutrality of Governing Council During Elections. Our~~That our AMA-RFS~~ Governing Council members shall maintain a neutral status in elections by:

~~(1) Not wearing campaign materials, except their own.~~
~~(2)~~(1) Not acting as campaign manager for any candidate.
~~(3)~~(2) Not endorsing candidates from the podium.
~~(4)~~(3) Not endorsing candidates as a Council.
~~(5)~~(4) Not endorsing candidates through the use of one's Governing Council title.
~~(6)~~(5) ~~Using discretion with respect to their personal endorsements.~~

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2. Voter Eligibility. All credentialed RFS Business Meeting Delegates and Business Meeting Alternate Delegates shall be eligible to vote. ~~Absentee ballots are not accepted. Members with conflicts should seek permission from their Council, State or specialty to vote on items of business being considered by the Assembly.~~

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

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

G. Method of Election & Endorsement.

1. Governing Council Elections.
   a) Uncontested elections: If after the call for nominations there is only one candidate for a position, the race shall be considered uncontested and the election shall be by acclamation, held immediately after the call for nominations.
   b) Contested elections: If after the call for nominations there is more than one candidate for a position, that race shall be considered contested, and the following method shall be used to elect:
      (1) Ballots for each position shall be listed in alphabetical order and used by the voter with one vote for each of the following positions: Chair-Elect, Vice Chair, Delegate, Speaker, and Member At-Large.
      (2) A ballot shall not be counted if there is more than one vote for any office on that ballot.
      (3) The candidate who receives a majority of legal ballots cast for a given office shall be elected to that office. If no candidate receives a majority on the first ballot, a runoff election shall be held between the candidates receiving the first and second largest number of votes.

(4) Election of Alternate Delegate. After the election of the Delegate, all unsuccessful candidates who were nominated for the office of Delegate, and who choose to be a candidate for Alternate Delegate, will be placed on a ballot for the election of the Alternate Delegate. Additionally, any candidate who was nominated for the office of Alternate Delegate shall also be placed on the same ballot. Each voting Representative to the Business Meeting who is present at the meeting may cast a ballot for the election of the Alternate Delegate from among those so nominated. Election to the office of Alternate Delegate requires a majority of the legal ballots cast. The remaining rules for election balloting in V.G.1.b.3 will apply.

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

2. Endorsement for RFS position on the Board of Trustees and elected Councils.
   a) Only one RFS member may be endorsed at the Business Meeting for each position. The endorsement shall be for a single election cycle and shall occur at the Interim meeting. The credentialed delegates may choose not to endorse any candidate.
   b) The ballot shall contain the name of each candidate as well as an option to select none of the candidates. On the ballot, affirmative votes may be cast for one candidate or no candidates.
   c) A candidate must receive a majority of legal votes to be endorsed. If no candidate receives a majority of votes, a runoff

election shall be held between the candidates receiving the first and second highest number of votes.

d) Late Endorsement. At the time of the RFS Annual Meeting, if no candidate has been endorsed, a candidate may seek endorsement by the Assembly. This is subject to the same rules described above and additionally requires a 2/3 affirmative vote of the Assembly for endorsement.

3. Election of the Sectional Delegates and Sectional Alternate Delegates.
   a) Candidates may seek endorsement from their program, state society, specialty society, Federal Service, or PIMA. All nominees for Sectional Delegate shall be listed on a single ballot with their endorsing society. Candidates who receive written endorsement from their endorsing constituent association or specialty society prior to the election shall be noted to indicate that their endorsing materials were received prior to the election.
   b) The voter must vote for exactly as many candidates as there are open positions.
   c) Ballots will be counted and delegates selected based on a majority of approval voting system.
   d) Should a candidate be successfully elected without a prior endorsement, he or she has 30 days to obtain and submit written notification of endorsement from an organization consistent with Section VIII.B.2.a. If such requirements are not met, the position shall be considered vacant.
   e) Limitations. There shall be a limit of two Sectional Delegates and two Sectional Alternate Delegates per state or specialty society.
      (1) If there are more than two nominees from an endorsing state or specialty society who receive a majority of votes, then only the two nominees who have the most votes shall be elected.
      (2) All other nominees from that society shall be eliminated from the remaining counting of ballots. This process will continue throughout the counting of ballots to ensure that there are only two RFS Sectional Delegates per endorsing state and specialty society.
   f) Unfilled Seats/Runoff Elections.
      (1) If there are unfilled seats after the election, a runoff election will be held between the remaining candidates. The candidate(s) who receive(s) the highest number of votes, with a majority of legal votes cast, shall be elected.

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

g) Sectional Alternate Delegate Elections.
(1) After the completion of the Sectional Delegate elections, all unsuccessful candidates will have the option to be considered in the election for Sectional Alternate Delegate alongside those candidates who ran specifically for Sectional Alternate Delegate.
(2) The Sectional Alternate Delegate elections shall follow the same procedure as the election for Sectional Delegates.

~~4. Election of Regional Leaders.~~
~~a) Timing. Election of a Regional Chair shall occur during the Annual Business Meeting.~~
~~b) Method. Election shall occur by in-person balloting. No proxy votes are allowed. The candidate receiving a majority of the votes will be elected Regional Chair.~~
~~c)~~h) ~~Additional Positions. Additional positions will be elected consistent with the method for the Regional Chair. Additional positions will be designated at the discretion of the Governing Council or Regional Council.~~

~~5.~~4. Balloting. Method of balloting will be coordinated by the staff, Speaker, and Vice Speaker in concurrence with the Rules Committee.
a) Ballots will be prepared and distributed by the Credentials Committee.
b) No ballots will be cast after the expiration of each voting period. Upon completion of ballot counting, the Chair of the Rules Committee will validate the election results by determining that each ballot is official, that the number of ballots cast is equal to or less than the number distributed and will then certify the results of the election. He or she will then immediately forward these results to the Business Meeting's presiding officer.
c) Upon receipt of the Rules Committee election results and verification, the Business Meeting's presiding officer will certify the results of these elections and announce to the Assembly the final and official results of these elections. Vote totals shall remain confidential and shall not be announced. Candidates

may ask for and receive vote totals in confidence. ~~Discretion is encouraged.~~

~~6.~~5. Appeals. Appeals of the election process and results must be made in writing to the presiding officer~~Speaker~~ no later than one hour after the official announcement of the final results.

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

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

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

VI. Resident Member on the Board of Trustees

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

B. Duties and Privileges.

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

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

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

VII. Resident/Fellow Member on AMA Councils

A. Selection.

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

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

B. Duties and Privileges.

1. Report at the Business Meeting. An opportunity will be provided to the resident/fellow member of all Councils to submit a report of the Council's activities at the Business Meeting biannually.

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

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

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

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

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

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

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

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

C. Duties and Privileges.

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

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

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

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

D. Seating.

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

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

E. Limitations.

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

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

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

F. Term.

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

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

G. Vacancies.

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

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

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

IX. Business Meeting

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

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

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

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

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

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

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

D. **Other Representatives to the Business Meeting.**

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

a) Apportionment. The number of delegates~~representatives~~ shall be 10% of the ~~average~~ number of registered RFS delegates and alternate delegates from the previous year.
b) Criteria for the At-Large Delegate positions include the following:
   (1) A candidate must be an AMA-RFS member;
   (2) A candidate must submit an application to the RFS Governing Council for consideration. In the event that all available At-Large positions are not filled by application to the Governing Council, these positions may be filled at the meeting (Annual or Interim) on a first-come, first served, basis.
c) Term. A candidate will be able to apply to serve in this position for one meeting (Interim or Annual) or for an academic year. Final determination shall be at the discretion of the Governing Council.
d) Limits. There are no term limits for these positions but candidates must reapply after each year or meeting at the discretion of the Governing Council.
e) ~~Vacancies. All vacant positions after Interim will be offered for Annual.~~

2. National Resident and Fellow Organizations.
a) Apportionment. Each national resident and fellow organization that has been approved by the Governing Council for representation in the RFS Assembly may select one representative and one alternate representative.
b) Criteria for Eligibility. National medical resident and fellow organizations that meet the following criteria may be considered for representation in the AMA Resident and Fellow Section Business Meeting:
   (1) The organization must be national in scope.
   (2) The organization must be composed primarily~~solely~~ of residents or fellows.
   (3) Membership in the organization must be available to all residents or fellows, without discrimination.
   (4) The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives.
   (5) The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.
c) Procedure. The organization must submit a written application containing sufficient information to establish that the organization meets the criteria described above. The application ideally should also include the following:
   (1) The charter, constitution, bylaws, and code of medical ethics of the application organization.

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

d) The Governing Council shall review the application. If it recommends that the organization be granted representation in the Resident and Fellow Section Business Meeting, the recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the organization may be represented in the Resident and Fellow Section Business Meeting.
(1) Organizations that seek membership within the RFS primarily shall also be encouraged to concurrently pursue membership to join the AMA's House of Delegates.

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

f) Rights and Responsibilities. Representatives of national resident and fellow organizations in the Resident and Fellow Section Business Meeting shall have the following rights and responsibilities:
(1) V~~Full v~~oting rights in the Business Meeting with the exception of the~~, except the~~ right to vote in any elections, starting at the conclusion of a two-year probationary period with regular attendance.
(2) Presenting its policies and opinions in the Business Meeting.
(3) Reporting on the actions of the RFS to members of their respective organizations.
(4) Cooperation in enhancing the AMA Resident and Fellow Section membership.

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

This petition can be submitted to the Governing Council at the subsequent meeting after being informed that their representation is recommended for discontinuation.

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

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

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

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

1. ~~Registered RFS members whose clinical responsibilities and travel arrangements require them to arrive during a day's business but after the close of credentialing may, at least four weeks prior to the meeting, petition the Governing Council to be allowed to credential late for the meeting. The decision to allow an RFS member to credential late will be made by majority vote of the Speaker, Vice Speaker, Delegate, Alternate Delegate, and Chair of the Rules Committee and communicated to the RFS member and the Credentialing Committee, in writing at least two weeks prior to the start of the meeting.~~
2. Previously registered RFS members who miss credentialing ~~due to unforeseeable travel delays~~ may~~, on a case-by-case basis~~ be allowed to credential late for that day's business on a case-by-case basis. This would be determined by a majority vote of the Speaker, Vice Speaker, and Chair of the Rules Committee, and communicated to the RFS member and the remainder of the Credentialing Committee.
3. Only credentialed RFS members present in the Business Meeting ~~room~~ may vote on items of business being considered.

F. Participation.

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

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

G. Procedure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. **Credentials Committee.** A ~~3- to 9-member~~ Credentialing~~ls~~ Committee shall be composed of 3 to 9 members~~formed~~, including one Chair. The Committee shall be responsible for consideration of all matters relating to the registration and certification of delegates including credentialing delegates for business meetings, verifying a quorum is present, and distributing ballots for elections.

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

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

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

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

X. Appointed Representation Outside of the Section

A. Positions Requiring Representation.

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

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

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

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

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

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

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

XI. Standing Committees

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

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

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

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

E. **Duties and Privileges.**

~~1. **Committee on Business and Economics**. The committee shall address topics including but not limited to financial and economic~~

Commented [5]: Hmmm...how do we feel about this language?

~~issues affecting physicians during their residency and fellowship, and personal and practice finance issues. The committee may also develop and implement policies and directives of the Assembly that are related to the business and economics of residents, fellows, and medicine. The RFS member of the AMA Council on Medical Service shall serve as an ex officio member of this committee.~~

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

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

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

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

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

~~Science and Public Health shall serve as an ex officio member of this committee.~~

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

~~8.~~1. ~~**Committee on Scientific Research.** The committee shall focus on topics including but not limited to assisting the Vice Speaker in organizing, running, and selecting posters for the annual Research Symposium, assisting in the creation of RFS positions on scientific issues, and developing and implementing policies and directives of the Assembly that are related to scientific research. The RFS member on the AMA Council on Science and Public Health shall serve as an ex officio member of this committee.~~

~~9.~~2. **Ad Hoc Committees.** The Governing Council may, at their discretion or when directed to do so by the Assembly, create ad hoc committees. These are created for a specific purpose. Members of the committee and length of committee existence are determined by the Governing Council unless otherwise specified by directive from the Assembly.

~~XII. Regions~~

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

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

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

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

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

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

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

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

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

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

9. Should any individual be a potential member of multiple regions due to educational, military, geographic and or specialty status, they must select their Regional affiliation at the time of the Business Meeting. No member shall be a voting member for more than one region nor shall they be allowed to change their regional affiliation during a Business Meeting.

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

D. Activities.

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

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

E. Regional Council.

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

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

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

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

~~XIII.~~XII. Miscellaneous

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

B. Amendments to the Internal Operating Procedures.

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

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

D. Endorsement of Candidates Not Otherwise Described Above. The Resident and Fellows Section does not endorse candidates for positions who are not currently members of the Resident and Fellow Section.

E. RFS Caucus in the House of Delegates.

1. The RFS Delegate and Alternate Delegate shall be responsible for leading the caucus consisting of all duly-elected and appointed RFS Sectional Delegates and Alternate Delegates. The role of the caucus

shall be to enact the will of the Assembly in the HOD. Any RFS member is welcomed to attend the RFS Caucus Meeting.

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

3. Internal votes taken by the RFS delegation shall guide the actions of the delegation for the meeting in question.

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

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

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: A
(I-23)

Introduced by: RFS Governing Council

Prepared by: RFS Committee on Public Health

Subject: Adopting a Neutral Stance on Medical Aid in Dying (MAID)

Referred to: Reference Committee

Introduction

Since the inception of the medical profession, alleviation of suffering has been considered a core tenant of the physician-role, particularly in the dying patient. Although current law and ethical norms acknowledge a patient's autonomy to decline or withdraw life-saving or life-sustaining treatment, society distinguishes this from other actions that hasten a person's death. Therefore, the practice of "Medical Aid in Dying" (MAID), elsewhere referred to "physician-aid in dying" (PAD) or "physician-assisted suicide" (PAS) remains highly controversial within the medical community and society at large.

In 2019, our RFS studied MAID (Report D, I-19; Appendix A) and our assembly subsequently passed 100.005R Medical Aid in Dying**,** which states, "Our AMA-RFS 1) support the AMA ending its practice of using the term "physician-assisted suicide" and instead replace it with "medical aid in dying"; 2) support protections for physicians and patients who participate in medical aid in-dying in states where it is legal; and 3) adopt a position of neutrality toward physician aid in dying." More recently (A-23), our RFS assembly considered Resolution 8, which proposed our AMA adopt a neutral stance on MAID. The reference committee recommended amendments to request further AMA study of this topic. The item was extracted for discussion and although there was overwhelming support to revisit AMA's long-held opposition to MAID, it was noted AMA Council of Ethical and Judicial Affairs (CEJA) had studied the issue in three recent reports in 2017, 2018 and 2019 (Appendix B), which were each debated at length in the House of Delegates and further study was unlikely to achieve resolution. Furthermore, it was expressed that an internal study by the RFS could bolster efforts to move the House to a position of neutrality. The resolution was adopted as amended to read as follows:

> RESOLVED, That our AMA adopt a neutral stance on medical aid in dying and respect the autonomy and right of self-determination of patients and physicians in this matter; and be it further
>
> RESOLVED, That our AMA-RFS study the benefits and risks of medical aid in dying, and to how such aid might affect improve the quality of end-of-life care.

The RFS Governing Council therefore assigned this report to the Committee on Public Health (CPH) for further study. In this report, we do not conduct a de novo ethical analysis of MAID, as this has been executed by multiple entities, including AMA CEJA. Our RFS adopted a position of neutrality based on the rationale that "there are diverse arguments for and against" the practice (Report D, I-19), both of which are equally valid and these opposing views are existentially irreconcilable. Therefore, this report approaches the issue through a public health lens; we first present an updated summary of medical professional organizations' positions on MAID and the current legal landscape in the United States. Additionally, we report on a literature review of MAID

utilization and outcomes since its legalization in the U.S. and its impact on quality of end-of-life care.

Methods

Policies and position statements on MAID by medical professional organizations were collected from review articles on the topic and from individual organization websites, when such policies were publicly available. Relevant court cases and state laws were identified via online search engines using the terms, “Medical Aid in Dying legalization”. With respect to MAID utilizations and outcomes, a comprehensive review of all primary literature involving MAID was not possible within the constraints of this report. Rather, a focused review was performed using search terms “Medical Aid in Dying” in conjunction with terms such as “utilization”, “outcomes”, “quality of life”, “bereavement”, “caregiver distress” and “harms” on both PubMed and Google Scholar. Both qualitative and quantitative studies of U.S. patients who pursued MAID were included. Articles that were limited to philosophical or ethical analysis, opinion pieces, and individual cases were excluded. Publications since 2019 were prioritized for review.

Definition of Terms

Given the sensitive nature of the topic, specificity of language is crucial. Medical aid in dying (MAID) is the term that will be used for the purposes of this report, defined as “a practice in which a physician provides a competent adult with a terminal illness with a prescription for a lethal dose of a drug at the request of the patient, which the patient intends to use to end his or her life.”[1] This has emerged as the preferred term, as it shifts the emphasis from the physician to the patient and connotes a legally valid medical practice. Additionally, prescribers may be nurse practitioners rather than physicians in some jurisdictions. The term also emphasizes the role of the provider as an aid or assistant rather than an active agent and clarifies that the act itself is not suicide.[2]

The more passive role of the physician as prescriber rather than administrator is the critical point of differentiation of MAID from euthanasia, which is defined in the AMA Code of Ethics as “the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering”[3]. Euthanasia can be “voluntary” at a patient’s request or “involuntary”, which “involves a patient who cannot provide active participation or may not be capable of making an informed decision at the time.”[4] Euthanasia is not the subject of this report.

The separation of “aid in dying” and “suicide” is less clear cut, but no less important. The AMA itself uses the term “physician assisted suicide” in lieu of MAID. However, the classification of this act as suicide is strongly rejected by many medical organizations including the American Academy of Hospice and Palliative Medicine, American Academy of Family Physicians, and American Public Health Association and legally differentiated in all states where MAID has been legalized.[5,6] Advocates point out that terminally ill patients seeking assisted death are not suicidal as their wishes are entirely dependent on their diagnosis; miraculous cure of their illness would remove their desire for death. Notably, patients participating in MAID are screened for mental illness including depression, to ensure this is not impacting their decision-making capacity. Another key distinction is that patients seeking MAID must have a life expectancy of less than six months. At this point in their illness trajectory, assisted death is not choosing between living and dying, but rather between one form of death and another.

The Current Legal Landscape

The legal landscape of MAID is varied across the United States and has been in flux for over 30 years. There was an attempt to answer this legal question at the level of the Supreme Court in two cases in 1997, *Washington v Glucksberg* and *Quill v Vacco*[7-9]. The court ultimately ruled that

MAID was not a right citizens are entitled to and the issue should be determined by individual states as they see fit. Specifically, *Washington v Glucksberg* stated that Washington's law at the time preventing physicians from assisting or aiding a patient in suicide was not in violation of the 14th amendment and assisting a suicide is not an individual liberty of citizens[7]. Similarly, *Quill v Vacco* stated that the laws in New York State that outlawed a physician from assisting suicide were upheld, along the lines that allowing a patient to die by refusing treatment was different than the active act of helping them to die by suicide of alternative means[8]. Thus the issue has fallen to the states to decide if and how they want this practice to be active and legal.

The first state to legalize the practice was Oregon in 1997, whose law and regulations remain intact to this day. Coined the "Death with Dignity Act", it has paved the way for patients and physicians to work towards MAID. To be eligible, one must be an Oregon resident, 18 years or older, have the capacity to make the decision, and have a terminal illness with a documented prognosis of less than six months.[10] Referral for psychiatric evaluation is required if there is concern that a psychiatric illness may be impairing the patient's judgment. The law also requires a patient to make two separate requests, including a written request on a specific state-required form, and institutes waiting periods. There must be 15 days separating the first request from the date the physician fills the prescription, with at least 48 hours between the second written request and filling the prescription[10].

Additional states that have passed legislation allowing MAID include Washington (2008)[11], Vermont (2013)[12], California (2015)[13], Colorado (2016)[14], Washington DC (2016)[15], Hawai'i (2018)[16], New Jersey (2019)[17], Maine (2019)[18], and New Mexico (2021)[19]. Notably, the practice is also legal in Montana (2009), the only state for legalization to occur through a state supreme court case, *Baxter v Montana*, that ruled the practice protected, with similar restrictions to Oregon, based on the state's Rights of the Terminally Ill Act from 1985[20]. Since this ruling, there have been several attempts to make the practice illegal again, but no attempts have succeeded so far. Other states have considered but not legalized MAID either through state legislation or ballot measure, including Arizona, Connecticut, Florida, Maryland, New York, Nevada and Tennessee. At the time of writing of this report, New York, Pennsylvania, and Massachusetts all currently have bills circulating in their legislative branches[21]; no other states have active legislation being considered.

Most aforementioned states where MAID is legal have enacted similar requirements and regulations to Oregon. Exceptions include Vermont and Hawaii. In 2023, Vermont dropped the restriction that someone seeking MAID must be a state resident, the first state to do so[22]. In Hawaii, the required waiting period from first notification to medication dispensation is just five days, and this can be waived entirely if the prescriber determines that death is imminent[22]. Hawaii is also the only state that allows APRNs to participate in the prescriber role, citing a lack of access to physicians in the state.[22] In 2021, California revised its End of Life Options Act to reduce its 15 day waiting period to 48 hours.

Internationally, the legal field is varied, but there are many countries that allow the practice. As of 2021, those countries include Canada, Germany, Switzerland, France, Italy, Luxembourg, the Netherlands, Belgium, Austria, New Zealand, parts of Australia, and Columbia.[23] Switzerland was the first to legalize the practice in 1942 and to allow individuals to assist the suicide of another person so long as the motives for doing so are not "selfish"[23]. The Netherlands and Belgium have some of the most controversial regulations for the practice since they designate some psychiatric illnesses as viable qualifying illnesses. Additionally, both countries have legalized MAID for minors as young as 12, though parental consent is required for those age 12-16[23]. New Zealand is the newest member of this list as its legislation passed in 2021 introducing the practice to the country[23].

Physician Group Surveys & Position Statements

Multiple state medical organizations have conducted surveys of physicians on the topic of MAID as part of their policy deliberation processes, and several have published their results. In a 2016 poll of Colorado Medical Society physicians, 56% of respondents were supportive of MAID legalization, 35% opposed and 9% were unsure[24]. A majority (60%) of Maryland physicians supported MedChi changing its position of opposition to MAID[25]; a similar proportion (62%) of Massachusetts physicians supported the proposed Massachusetts End-of-Life Option Act in a 2017 poll[26]. Two recent national physician polls found similar levels of support for MAID legalization, 57% and 60% respectively;[27,28] although only 13% of physicians indicated they would personally participate in prescribing lethal medications to patients. Collectively, these polls indicate a considerable shift in opinion within the profession, as polls conducted before 2010 consistently found fewer than 50% of physicians were in support of MAID.[28]

Several national specialty organizations[29] and state medical societies have released policy statements describing their position toward MAID (Table 1). Notably, the AAP position is specific to the practice as it pertains to children. Organizations that have adopted positions of neutrality shared common themes in their rationale: acknowledgment of the lack of consensus among physicians, commitment to the patient-physician relationship, and deference to the public on the decision of legalization. Positions of support emphasize patient autonomy. Positions of opposition cited concerns of unintended negative consequences and of the erosion of trust in the medical profession.

Table 1. Physician Organizations' Positions on Medical Aid in Dying

National/Specialty Medical Organizations	
Support	
American Medical Women's Association (2018)	"AMWA believes the physician should have the right to engage in practice wherein they may provide a terminally ill patient with, but not administer, a lethal dose of medication and/or medical knowledge, so that the patient can hasten his/her death. This practice is known as medical aid in dying."[30]
American Public Health Association (2008)	"The American Public Health Association…supports allowing a mentally competent, terminally ill adult to obtain a prescription for medication that the person could self-administer to control the time, place, and manner of his or her impending death, where safeguards equivalent to those in the Oregon DDA are in place."[31]
American Medical Student Association (2008)	"The American Medical Student Association supports passage of aid in dying laws that empower terminally ill patients who have decisional capacity to hasten what might otherwise be a protracted, undignified or extremely painful death… It should be a last resort option in patient care."[32]
GLMA: Health Professionals Advancing LGBTQ+ Equality (2022)	"GLMA, health professionals advancing LGBTQ+ equality endorses health professional organization advocacy, state and federal legislation, or executive or judicial action that support medical aid in dying, an approach that allows people to access the full range of end-of-life care options, including to voluntarily, with informed consent, obtain medication from their clinician supporting their autonomy to hasten their death in a peaceful, humane, and dignified manner."[33]
Neutrality	

American Academy of Family Physicians (2018)	"RESOLVED, That the American Academy of Family Physicians adopt a position of engaged neutrality toward medical-aid-in-dying as a personal end-of-life decision in the context of the physician-patient relationship…"[34]
American Academy of Hospice and Palliative Medicine (2016)	"A diversity of positions exists in society, in medicine, and among members of the American Academy of Hospice and Palliative Medicine (AAHPM). AAHPM acknowledges that morally conscientious individuals adhere to a broad range of positions on this issue. AAHPM takes a position of studied neutrality on the subject of whether PAD should be legally permitted or prohibited."[35]
American Academy of Neurology (2018)	"The AAN has decided to retire its 1998 position on 'Assisted suicide, euthanasia, and the neurologist' and to leave the decision of whether to practice or not to practice lawful physician-hastened death to the conscientious judgment of its members acting on behalf of their patients."[36]
Opposition	
American Medical Association (2019)	"Physicians must not perform euthanasia or participate in assisted suicide…It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[37]
American College of Physicians (2017)	"On the basis of substantive ethics, clinical practice, policy, and other concerns articulated in this position paper, the ACP does not support legalization of physician-assisted suicide."[38]
American Academy of Pediatrics (2000)	"The Academy offers guidance on responding to requests for hastening death, but does not support the practice of physician-assisted suicide or euthanasia for children."[39]
National Hospice and Palliative Care Organization (2021)	"National Hospice and Palliative Care Organization (NHPCO) supports individuals' rights to exercise autonomy as is legal in their communities and seeks to provide assistance to member organizations in communities where medical aid in dying (MAID) is an option. Nevertheless…in light of the underuse of hospice and palliative care to alleviate suffering, lack of comprehensive health care for persons with serious illness, lack of research about the outcomes of MAID, concerns of disability rights advocates regarding protections from coercion, longstanding racial bias in medicine, disparities in health and medical care, and lack of protections to ensure voluntary participation, NHPCO opposes legally accelerated death as a societal option."[40]
Society for Post-Acute and Long-Term Care Medicine (1997)	"AMDA opposes any physician involvement in assisted suicide or active euthanasia of any person regardless of age…Our position recognizes that physician involvement in assisted suicide or active euthanasia would erode the trust vital to the doctor/patient relationship."[41]
World Medical Association (2022)	"WMA remains firmly opposed to euthanasia and physician-assisted suicide, as set forth in the WMA Declaration on Euthanasia and Physician-Assisted Suicide."[42]
Acknowledgement without position	

American College of Obstetricians and Gynecologists (2015)	"On rare occasions, physicians may be asked by a patient for assistance in hastening the time of her death…When this occurs, enhanced palliative care efforts, expert pain management, and counseling are all appropriate to address the patient's physical suffering and emotional distress, and the physician is encouraged to use these resources."[43]
American Psychiatric Association (2017)	"As our society continues to explore physician-assisted death as a legally available option, collection and analysis of vital data will be essential. We recommend that all jurisdictions follow a mandatory data collection model exemplified by Oregon. Additional information should be collected about patients referred for mental health assessment, their psychiatric diagnoses, the outcomes of referral, and subsequent outcomes."[44]
State Medical Organizations	
Neutrality	
Rhode Island Medical Society (1996)	"In 1996, the Rhode Island Medical Society (RIMS) passed a resolution on physician-assisted suicide, which called for RIMS to: a) adopt a neutral position with regard to physician assisted suicide b) and reaffirm its opposition to legislation that would attach criminal penalties to acts or omissions that occur in the exercise of medical judgment within the doctor patients relationship, including such acts or omissions as may be associated with physician-assisted suicide, pain management or palliative care for the terminally ill."[45]
California Medical Association (2015)	"Despite the remarkable medical breakthroughs we've made and the world-class hospice or palliative care we can provide, it isn't always enough. The decision to participate in the End of Life Option Act is a very personal one between a doctor and their patient, which is why CMA has removed policy that outright objects to physicians aiding terminally ill patients in end of life options."[46]
Colorado Medical Association (2016)	"In those instances where state law or precedent permits physicians to assist terminal patients to self administer a lethal dose of medication with the intention of physician-assisted death: (1) Physicians and patients should be allowed to pursue options that do not violate either party's fundamental values; and (2) Adequate protections must be in place to protect both physicians and patients."[47]
Maryland Medical Association (2016)	"Resolved, that MedChi change its policy on physician assisted suicide (aid-in-dying) from "oppose" to position of "neutral" on Maryland aid-in-dying legislation"[48]
Medical Society of the District of Columbia (2016)	"The Board found that physician-assisted suicide and end-of- life care are complex issues with no clear consensus. The Board recognized the AMA position on physician-assisted suicide…[and] took no position on the bill."[49]
Oregon Medical Association (2017)	"RESOLVED, that the OMA change its official position on the law from opposed to neutral…OMA supports and advocates for compassionate and competent palliative care at the end of life and, furthermore, acknowledges that medical efforts to eliminate irreversible and extreme pain and suffering at the end of life are an appropriate medical response that may result in hastening the patient's death."[50]
Massachusetts Medical Society (2017)	"In assuming the term 'neutral engagement,'...[we will] serve as a medical and scientific resource to inform legislative efforts that will support patient and physician shared decision making regarding medical aid-in-dying,

	provided that physicians shall not be required to provide medical aid-in-dying that involves prescribing lethal doses of medication if it violates personally held ethical principles."[51]
Minnesota Medical Association (2017)	"Physician aid-in-dying raises significant clinical, ethical, and legal issues. A diversity of opinion exists in society, in medicine, and among members of the Minnesota Medical Association. The MMA acknowledges that principled, ethical physicians hold a broad range of positions on this issue.The MMA will oppose any aid-in-dying legislation that fails to adequately safeguard the interests of patients or physicians."[52]
Nevada State Medical Society (2017)	"The association doesn't have a majority consensus among its members (on this legislation). That's why we've taken a neutral stance."[53]
Vermont Medical Society (2017)	"Even when physicians use all the tools at hand to care for pain and suffering, a small number of patients still suffer. Each of these patients is unique; each one of the patients will challenge the caregiver's skills in the extreme; and each one's care should be highly individualized and decided in private amongst the patient, physician and family. The Vermont Medical Society recognizes that medical aid in dying, in the form of Vermont Act 39, is a legal option that could be made in the context of the physician-patient relationship. Recognizing that principled physicians disagree about the ethics of Act 39, the Vermont Medical Society is committed to protecting its members' freedom to decide whether to participate in medical aid in dying according to their own values and beliefs."[54]
New Mexico Medical Society (2018)	"NMMS adopts a position of engaged neutrality regarding medical aid in dying in order to serve as a resource to lawmakers, physicians and the public, to ensure that medical aid in dying be practiced only by a duly licensed physician in conformance with standards of good medical practice and statutory authority, and to protect physicians' freedom to participate or not participate in medical aid in dying according to his or her personal conscience"[55]
Connecticut State Medical Society (2019)	"Unanimity within the physician community on the physician's role during the transition from life to death no longer exists. We have experienced a clear and unmistakable plurality of opinion on this subject both within the medical community and in society, with proponents on each side defending the ethics of their position utilizing the principles of beneficence and nonmaleficence."[56]
Maine Medical Association (2019)	"Whether to establish in Maine law, a pathway for physician-assisted death is a policy making decision for Maine voters and their elected representatives to make. While MMA will take no position on the central issue of physician-assisted death, it will testify as needed on any provisions that might adversely affect patients or physicians and it will continue its longstanding advocacy for the best possible end-of-life care, including hospice care."[57]
Medical Society of Virginia (2022)	"The Medical Society of Virginia adopts a position of engaged neutrality toward medical aid in dying, which is the process whereby adult terminally ill patients of sound mind ask for and receive prescription medication that they may self-administer to hasten death."[58]
Opposition	
Wisconsin Medical Society (2016)	"Physicians must not perform euthanasia or participate in assisted suicide… In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of

	involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time."[59]
Washington State Medical Society (2018)	"The WSMA remains committed to professional standards that will always allow our patients to feel safe under our care without fear regarding any conflicting motives physicians may have. The WSMA remains committed to providing support for medical interventions that foster quality end of life care without providing a means for patients to hasten their own death."[60]
Medical Society of the State of New York (2020)	"Although relief of suffering has always been a fundamental duty in medical practice, relief of suffering through shortening of life has not. Moreover, the social and societal implications of such a fundamental change cannot be fully contemplated. MSSNY supports all appropriate efforts to promote patient autonomy, promote patient dignity, and to relieve suffering associated with severe and advanced diseases. Physicians should not perform euthanasia or participate in assisted suicide.[61]
Michigan State Medical Society (2021)	"MSMS adopts the following position of the American Medical Association on physician assisted suicide: Allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."[62]
Louisiana State Medical Society (2021)	"Physicians should never participate in the active administration of any agent for the purpose of terminating a patient's life, nor provide any medication, technique, or advice necessary for the termination of life, including referral to a physician who would assist in termination of life."[63]
Illinois State Medical Society (2023)	"RESOLVED, that the Illinois State Medical Society (ISMS) reaffirm its position which opposes and declares as unethical physician participation in active euthanasia or physician-aided suicide"[64]

i. Dates indicate the year policy was adopted or last reaffirmed

Interestingly, different entities have drawn divergent conclusions from the 2019 AMA CEJA report. Most have interpreted the report's recommendation not to amend the Code of Medical Ethics (COE) as a reaffirmation of the AMA's opposition to MAID, and indeed state medical associations such as MSMS have cited the AMA's opposing position in their own policies. However, others have interpreted the 2019 report as providing a new interpretation of the COE that provides an ethical basis for physicians who support MAID.[65] Indeed, when Dr. Lazarus presented the report on behalf of CEJA, he stated with the adoption of the report they would, "Put it up on our website and include [two opinions] which outline why CEJA provides a home for both those who support physician-assisted suicide and those who oppose it."[66] Now, the Code of Ethics section on "Physician-Assisted Suicide" presents both Opinion 5.7 and 1.1.7, the latter of which discusses physician exercise of conscience.[67] Additionally, a preamble to these two opinions states, "Thoughtful, morally admirable individuals hold diverging, yet equally deeply held and well-considered perspectives about physician-assisted suicide. Nonetheless, at the core of public and professional debate about physician-assisted suicide is the aspiration that every patient come to the end of life as free as possible from suffering that does not serve the patient's deepest self-defining beliefs. Supporters and opponents share a fundamental commitment to values of care, compassion, respect, and dignity; they diverge in drawing different moral conclusions from those underlying values in equally good faith." However, AMA policies H-270.965 and H-140.966, which have been reaffirmed since this report, both emphasize strong opposition to MAID. While it's clear the council was attempting to placate physicians on both sides of this debate, our current policy is simultaneously nebulous and restrictive.

MAID Utilization and Impact on Quality of End-of-Life Care

Although legal access to MAID is becoming more prevalent both in the United States and around the world, utilization remains extremely limited. Cumulatively, over more than 20 years in the United States, a total of 5,329 people have died via MAID, and a total of 8,451 people have received a prescription.[68] This represents a small percentage of total deaths; for example in California, 486 MAID deaths accounted for just 0.14% of the state's 327,855 total deaths in 2021.[69] Oregon, where MAID has been legal for over 25 years, has the highest per-capita usage of MAID, comprising 1.0% of deaths in 2021.[70]

As all states where MAID is legal have stringent annual reporting requirements, we have longitudinal data on the demographics of individuals who have engaged in MAID. According to cumulative data combining all these state reports, patients that pursued MAID were 52% male, disproportionately white (94%) and college educated (72%).[71] Patients who pursued MAID were generally integrated into traditional palliative care services with over 86% of all patients enrolled in hospice. The overwhelmingly most common diagnosis was advanced malignancy at over 70% of all patients, followed by neurodegenerative diseases such as ALS or Huntington's disease (11%), then advanced lung (6%) or heart disease (6%).[71]

While it is not possible to gather self-reported post-hoc data on the patient's experience of MAID, there has been some data contributed by physicians present at bedside in Oregon suggesting there are relatively few complications while ingesting the prescribed medications, and these mostly result from difficulty swallowing the medications.[70] A larger systematic review of all available MAID data from both Oregon and Washington found 4% of patients experienced complications, again with the most common being difficulty ingesting or regurgitation of the lethal medication, and an overall short median time to unconsciousness and death.[72] However, the extant data is limited as most MAID participants do not have physicians at bedside at the time of ingestion and/or death and therefore do not have data on complications submitted. This may be in part impacted by institutional guidelines against staff being present when the patient ingests the prescribed medications or against MAID happening in a facility at all.[73] Additionally, extent of data reporting is not uniform across states; for example, Colorado does not collect data on hospice enrollment at the time of MAID request and Montana collects no data on MAID deaths whatsoever.[74]

The impact of MAID on quality of life (QOL) at the end of life is an extremely difficult topic to study, in large part because QOL metrics typically rely on self-reported data since it is inherently a subjective measure. Absent patients' perspectives, researchers have approached this question by examining the impact on various other surrogate markers, such as family-reported outcomes, family bereavement, and death location, though even works on these outcomes are limited. A 2023 systematic review of bereavement outcomes for family members of individuals who engaged with medical aid in dying found equivocal results, with no clear difference in bereavement based on manner of death being found.[75] Dying at home is often a goal of patients engaged in end-of-life care discussions. In Oregon, 91.7% of MAID participants in 2022 died at home. This is consistent with data combined from all state databases about 90% of patients who died at home, with 8% dying in an inpatient hospice or nursing home facility.[68,70]

In assessing QOL at the end-of-life, it is worth considering alternative pathways that terminally ill patients may take in locale where MAID is illegal or inaccessible. Patients with terminal cancer are at twice the risk of suicide than the general population[76], with the three most common methods being firearms, poisoning/overdose, and hanging/suffocation[77]. Another method patients may use to hasten death is voluntary cessation of eating and drinking. In one qualitative study of hospice workers in Washington state, participants reflected on the suffering they witnessed in patients who had pursued these avenues, seemingly unaware of MAID as a legal alternative.[78] Many

hospice agencies have institutional policies for religious or philosophical reasons which preclude discussion of MAID with patients. Hospice patients whose symptoms cannot be managed at home can be escalated to inpatient care for intensive symptom management. A palliative treatment of last resort for those with intractable pain and suffering is palliative sedation, which predictably leads to death from dehydration within days to weeks. No studies have attempted to quantify whether the option of MAID has impacted the incidence of these alternative outcomes.

Limitations

Our study had several limitations which are worth noting. Not all physician organization websites provide public access to their policy compendiums, so our review of these positions may exclude those organizations. Additionally, new positions adopted within the last 6-months of this report may not yet be reflected on organization websites. State chapters of national specialty organizations which have adopted policies contrary to or independent of their national specialty organizations were not included in our analysis.

As previously stated, it was not feasible to conduct a systematic literature review in the timeframe allocated for this report. Our report did not include analysis of data collected from outside of the U.S., and therefore excluded countries more experienced with MAID. Older publications were de-emphasized; however our study included several systematic reviews which did capture older data in their aggregates.

Conclusion

In considering the issue of medical aid in dying, many specialty and state medical organizations that have adopted a neutral position cite rationale similar to our RFS. Available data on physician attitudes and moral conclusions on MAID and a growing number of physician organizations dropping opposition to MAID would suggest that a plurality, if not a majority, of physicians believe either that MAID should be legalized, or that this question should be determined by the public. Since adoption of the 2019 CEJA report, which in their own words sought to "provide a home" for physicians both supportive of and in opposition to MAID, AMA's policy of opposition to MAID is now arguably in conflict with its own code of ethics and requires re-examination. While MAID utilization has gradually increased in jurisdictions where it is legal, even in Oregon overall usage remains low. Concerns of abuse of the practice and disproportionate utilization among socially marginalized groups have not borne out in available data; in fact, patients seeking MAID are disproportionately white, well-educated and affluent. Considerable additional research is warranted to assess the impact of MAID on end-of-life care.

In summary, this report affirms the need for RFS position statement 100.006R, "Adopting a Neutral Stance on Medical Aid and Dying," and considers its second aim accomplished.

Recommendation

1. RESOLVED, that our RFS amend 100.006R, "Adopting a Neutral Stance on Medical Aid and Dying," by deletion to read as follows:

   "That our AMA-RFS support our AMA in adopting a neutral stance on medical aid in dying and respect the autonomy and right of self-determination of patients and physicians in this matter.~~; and that our AMA-RFS study the benefits and risks of medical aid in dying, and how such aid might affect the quality of end-of-life care~~."

Relevant RFS Position Statements:

100.002R Education on Medical Aid in Dying: That our AMA-RFS support AMA's effort to provide national leadership through sponsorship of forums and dissemination of information regarding the ethical dilemma of medical aid in dying and other end of life decisions. (Substitute Resolution 28, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

100.005R Medical Aid in Dying: That our AMA-RFS support the AMA ending its practice of using the term "physician-assisted suicide" and instead replace it with "medical aid in dying"; support protections for physicians and patients who participate in medical aid in-dying in states where it is legal; and adopt a position of neutrality toward physician aid in dying. (Report D, A-19)

Relevant AMA Policy:

Decisions Near the End of Life H-140.966
Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.
(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.
(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.
(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.
(5) Our AMA supports continued research into and education concerning pain management.
Citation: [CEJA Rep. B, A-91; Reaffirmed by BOT Rep. 59, A-96; Reaffirmation A-97; Appended: Sub. Res. 514, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed in lieu of Res. 211, I-13; Reaffirmed: BOT Rep. 05, I-16]

Physician-Assisted Suicide H-270.965
Our AMA strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer.
Citation: [Sub. Res, 5, I-98; Reaffirmed: CEJA Rep. 11, A-08; Reaffirmed: BOT Rep. 09, A-18]

Code of Medical Ethics: 5.7 Physician-Assisted Suicide
Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:
(a) Should not abandon a patient once it is determined that cure is impossible.
(b) Must respect patient autonomy.
(c) Must provide good communication and emotional support.
(d) Must provide appropriate comfort care and adequate pain control

Code of Medical Ethics: 5.8 Euthanasia

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.
It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.
However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.
The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life.
Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Physicians:
(a) Should not abandon a patient once it is determined that a cure is impossible.
(b) Must respect patient autonomy.
(c) Must provide good communication and emotional support.
(d) Must provide appropriate comfort care and adequate pain control.

Code of Medical Ethics 1.1.7 Physician Exercise of Conscience
Physicians are expected to uphold the ethical norms of their profession, including fidelity to patients and respect for patient self-determination. Yet physicians are not defined solely by their profession. They are moral agents in their own right and, like their patients, are informed by and committed to diverse cultural, religious, and philosophical traditions and beliefs. For some physicians, their professional calling is imbued with their foundational beliefs as persons, and at times the expectation that physicians will put patients' needs and preferences first may be in tension with the need to sustain moral integrity and continuity across both personal and professional life. Preserving opportunity for physicians to act (or to refrain from acting) in accordance with the dictates of conscience in their professional practice is important for preserving the integrity of the medical profession as well as the integrity of the individual physician, on which patients and the public rely. Thus physicians should have considerable latitude to practice in accord with well-considered, deeply held beliefs that are central to their self-identities.
Physicians' freedom to act according to conscience is not unlimited, however. Physicians are expected to provide care in emergencies, honor patients' informed decisions to refuse life-sustaining treatment, and respect basic civil liberties and not discriminate against individuals in deciding whether to enter into a professional relationship with a new patient. In other circumstances, physicians may be able to act (or refrain from acting) in accordance with the dictates of their conscience without violating their professional obligations. Several factors impinge on the decision to act according to conscience. Physicians have stronger obligations to patients with whom they have a patient-physician relationship, especially one of long standing; when there is imminent risk of foreseeable harm to the patient or delay in access to treatment would significantly adversely affect the patient's physical or emotional well-being; and when the patient is not reasonably able to access needed treatment from another qualified physician.
In following conscience, physicians should:
(a) Thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients.
(b) Before entering into a patient-physician relationship, make clear any specific interventions or services the physician cannot in good conscience provide because they are contrary to the physician's deeply held personal beliefs, focusing on interventions or services a patient might otherwise reasonably expect the practice to offer.
(c) Take care that their actions do not discriminate against or unduly burden individual patients or populations of patients and do not adversely affect patient or public trust.
(d) Be mindful of the burden their actions may place on fellow professionals.
(e) Uphold standards of informed consent and inform the patient about all relevant options for treatment, including options to which the physician morally objects.
(f) In general, physicians should refer a patient to another physician or institution to provide treatment the physician declines to offer. When a deeply held, well-considered personal belief leads a physician also to decline to refer, the physician should offer impartial guidance to patients about how to inform themselves regarding access to desired services.
(g) Continue to provide other ongoing care for the patient or formally terminate the patient physician relationship in keeping with ethics guidance.

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Appendix A: RFS Report D, I-19
https://docs.google.com/document/d/1GEXTCnXKdPcicvvT7yM2ohYIIQivE2uQ/edit?usp=sharing&ouid=105121186456506105097&rtpof=true&sd=true

Appendix B: REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (2-A-19)
https://www.ama-assn.org/system/files/2019-05/a19-ceja2.pdf

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 1
(I-23)

Introduced by: Christina Wang, MD; Dayna Isaacs, MD, MPH; Dan Pfeifle, MD

Subject: Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation

Referred to: Reference Committee

Whereas, The practice of off-label prescribing, the use of pharmaceutical drugs for an unapproved indication or in an unapproved age group, dosage, or route of administration, is a legal and often necessary aspect of medical practice; and

Whereas, The prescription drug Ozempic, a glucagon-like peptide-1 (GLP-1) receptor agonist used for the treatment of type 2 diabetes, is chemically identical to the more expensive weight loss drug Wegovy, both produced by pharmaceutical company Novo Nordisk; and

Whereas, The price discrepancy between Ozempic and Wegovy, despite their chemical identity, places an undue financial burden on patients seeking weight loss treatment; and

Whereas, The stepwise approach of dosing for both medications is 0.25mg, 0.5mg, 1mg, and a maximum dose of 2.0mg (for Ozempic) and 2.4mg (for Wegovy); and

Whereas, Novo Nordisk is threatening to report physicians prescribing Ozempic for weight loss to state medical boards, potentially jeopardizing physicians' licenses; and

Whereas, Such threats from pharmaceutical companies interfere with the practice of medicine and potentially compromise patient care; and

Whereas, Insurance companies have also sent letters to physicians warning that prescribing Ozempic for off-label indications for weight loss could lead to reporting of activity to state licensure board, federal and/or state law enforcement; therefore be it

RESOLVED, That our AMA advocate for transparency, accountability, and fair pricing practices in pharmaceutical pricing, opposing differential pricing of medications manufactured by the same company with the same active ingredient, without clear clinical necessity, such as Wegovy and Ozempic; and be it further

RESOLVED, That our AMA condemn interference with a physicians’ ability to prescribe one medication over another with the same active ingredient, without risk of harassment, prosecution, or loss of their medical license, and calls on regulatory authorities to investigate and take appropriate action against such practices; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the 2023 Interim Meeting.

Fiscal Note: Minimal

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RELEVANT AMA POLICY:

Patient Access to Treatments Prescribed by Their Physicians H-120.988

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 2
(I-23)

Introduced by:	Peter DeRosa, MD; Daniel Lee; MD; David Savage, MD; Michael Visenio, MD; Alexandria Wellman, MD; Gunjan Malhotra, MD
Subject:	AMA Policy D-275.948 Title Change and Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards
Referred to:	Reference Committee

Whereas, Physicians strive for the highest degree of patient care and professionalism[1]; and

Whereas, Professionalism in medicine has been achieved through self-governance and self-regulation[1]; and

Whereas, Non-physicians serving in executive and board leadership roles in physician organizations compromises the objective of self-regulation and self-governance; and

Whereas, The president and CEO of the National Resident Matching Program (NRMP) is a non-physician and holds the following credentials D.H.Sc., MBA, BSN and has also never participated in the MATCH, never completed a residency or fellowship and yet also held prior leadership positions overseeing accreditation of physician residency and fellowship programs, was an executive director at the ACGME and held the position of designated institution official (DIO) for a graduate medical education (GME) program[2]; and

Whereas, The newly elected vice chair of the National Board of Medical Examiners (NBME) is a non-physician and holds the following credentials RN, PhD, received a bachelor of science in nursing, master of science in nursing education and doctor of philosophy in theory development and research in nursing and has never taken any NBME examination for board certification and yet now holds the position of vice chair of the organization[3]; and

Whereas, The current chair of the Accreditation Council for Graduate Medical Education (ACGME) is a non-physician and holds the following credentials MA and who is co-founder for a strategic human resource consulting firm[4]; and

Whereas, The recently elected President and current Vice President of the American College of Cardiology (ACC) is a non-physician and holds the following credentials RN, MSN and is president and CEO of Cardiovascular Management of Illinois, a cardiology physician practice management company[5]; and

Whereas, Non-physicians, who do not themselves go through physician education, accreditation, certification, licensing, and credentialing, may have difficulty appreciating the needs and challenges of physician trainees and practicing physicians and therefore should not be making major decisions for physicians and representing physicians in the highest roles of these organizations; and

Whereas, The purpose of having non-physicians on the physician boards was to have a public voice on these boards not to lead the organization itself in the highest roles of the organizations; and

Whereas, Non-physicians can participate on physician boards as a public member without leading the organization in the highest roles; and

Whereas, Our AMA leads the “stop the scope creep campaign” educating legislators about the differences in training between physicians and non-physicians; and

Whereas, Having non-physicians leading physician boards is contradictory to the AMA message about scope creep and the importance of education; and

Whereas, Our advocacy to legislators about the importance of physician education is compromised if we have non-physicians in the highest roles determining physician standards; and

Whereas, There is no shortage of highly qualified physicians that would be able to excel in these leadership roles now held by non-physicians which would be consistent with our AMA stop the scope creep campaign to have physicians in these roles; and

Whereas, Having these non-physician individuals lead national standard-setting organizations in our physician profession undermines physician confidence in these organizations; and

Whereas, The current title of policy D-275.948 does not match the content of the policy; therefore be it

RESOLVED, That our AMA change the title of policy D-275.948 by substitution to read as follows:

> ~~Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training~~ Addressing Non-Physician Positions and Participation on Physician Regulatory Boards and Bodies and Potential Conflicts of Interest D-275.948; and be it further

RESOLVED, That our AMA work with relevant stakeholders and physician regulatory bodies and boards involved in physician education, accreditation, certification, licensing and credentialing to advocate for physician (MD or DO) led executive leadership on these regulatory bodies and boards in order to be consistent with our “stop scope creep” advocacy and prevent undermining physician confidence in these organizations; and be it further

RESOLVED, That our AMA create a task force with the mission to increase physician (MD or DO) participation in, awareness of and opportunities in leadership positions on physician regulatory bodies and boards through mechanisms including but not limited to mentorship programs, leadership training programs, nominations, publicizing the opportunities to the membership and creating a centralized list of required qualifications and methods to apply for these positions.

Fiscal Note: Moderate

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5. https://www.acc.org/About-ACC/Leadership/Officers-and-Trustees

Relevant AMA Policy:

Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training D-275.948

1. Our AMA acknowledges that a conflict of interest exists when non-physician health care professionals hold positions on physician regulatory bodies or physician boards when these individuals represent a field that either possesses or seeks to possess the ability to practice without physician supervision.
2. Our AMA will encourage key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (A) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected; and (B) review and amend their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision. Citation: [CME Rep. 5, A-22Modified: Res. 323, A-23]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 3
(I-23)

Introduced by: Whitney Sambhariya, MD, PhD

Subject: Early and Periodic Eye Exams for Adults

Referred to: Reference Committee

Whereas, Eye exams are a screening tool that uses evidence based medicine to assess for the presence or absence of diseases to provide treatment and work to preserve vision[1-2]; and

Whereas, The American Academy of Ophthalmology (AAO) recommends that all adults get a complete eye examination by an ophthalmologist at age 40 in order to detect common diseases, provide early treatment, and preserve vision[3-4]; and

Whereas, Those under the age of 40 who are healthy and have good vision should receive a eye exam every 5-10 years[3-5]; and

Whereas, Adults who suffer from chronic systemic conditions are more likely to develop eye disorders and subsequent vision loss from eye disorders than their healthy peers and would benefit from earlier screening to better manage their disorders[6-7]; and

Whereas, Diseases such as diabetes, high blood pressure, and a family history of eye disease significantly raise an individual's chances of developing eye related disease and are not recommended to wait to get an eye exam until they are 40 years old[3,6-7]; and

Whereas, Diabetic patients can develop diabetic retinopathy, earlier cataracts, and glaucoma; this increased risk does not start when the patient can be classified as elderly, but has rather been shown to start from the age of 45 according to the Centers for Disease Control and Prevention (CDC)[8-11]; and

Whereas, According to the CDC, approximately 4.5% of adults aged from 45-64 have undiagnosed diabetes, something which a baseline or routine eye exam could aid in diagnosing as according to the National Eye Institute[8-12]; and

Whereas, 40-45% of Americans with diabetes have visibly evident diabetic retinopathy, which can show up early in the disease process of diabetes[11]; and

Whereas, According to the CDC, early detection and treatment can prevent or delay blindness due to diabetic retinopathy in 90% of people with diabetes, but 50% or more of them don’t get

their eyes examined or are diagnosed too late for effective treatment and can therefore benefit from early eye examinations[1]; and

Whereas, Hypertensive patients likewise have similar ocular manifestations such as: hypertensive retinopathy, choroidopathy, and ocular neuropathy[13-14]; and

Whereas, Earlier screening and treatment for these patients have been shown to reduce the burden of blindness due to diabetic retinopathy and hypertensive eye disease[15]; and

Whereas, Diabetes and hypertension continue to increase in prevalence in the U.S. making this a growing issue that should be addressed sooner rather than later to decrease sequelae and financial burden[9,16]; and

Whereas, Medicare and other insurance companies do not cover routine eye examinations without a pre-existing diagnosis[17]; and

Whereas, The AMA supports evidence based screening in policy G-600.064, “AMA Endorsement of Screening Tests or Standards,” stating "Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations."[18]; and

Whereas, The AMA has policy supporting eye screenings for children (Encouraging Vision Screenings for Schoolchildren H-425.977) and for the elderly (Eye Exams for the Elderly H-25.990); however, for all adults, but especially for those adults at high risk, screenings need to occur between childhood and old age[19-20]; and

Whereas, The AAO has policy that supports the screening of children, elderly, as well as healthy adults at age 40[21]; and

Whereas, Particularly, the AAO supports that all individuals who are “at high risk of developing ocular abnormalities related to systemic diseases such as diabetes mellitus and hypertension or who have a family history of eye disease, require periodic comprehensive eye examinations to prevent or minimize vision loss[21]”; and

Whereas, The AMA does not have a policy encouraging eye screenings for either adults between childhood and elderliness nor those especially vulnerable adults who are at high risk of developing ocular abnormalities related to systemic diseases such as diabetes mellitus and hypertension or who have a family history of eye disease and addressing this gap will actively decrease vision loss; and

Whereas, Current United States Preventive Services Task Force (USPSTF) guidelines do not have any recommendations regarding adult eye examinations and have only weighed in on the

evidence regarding vision screening in which they say the "evidence is insufficient to assess the balance of benefits and harms of screening for impaired visual acuity in older adults[22]"; and

Whereas, Vision screening as discussed in the USPSTF is a completely distinct diagnostic tool to an eye examination which is discussed in this resolution; and

Whereas, The AAO describes vision screening as a distinct entity from eye examinations; and furthermore that vision screenings are unable "to provide the same results as a comprehensive eye and vision examination" from an ophthalmologist or optometrist and that "Comprehensive eye examinations are the only effective way to confirm or rule out any eye disease[23]"; and

Whereas, This is especially true in the setting of undiagnosed hypertensive and diabetic retinopathies, where vision loss happens late in the course of the disease and where, according to the CDC, patients "may not notice symptoms in the early stage. That's why it's very important to get a dilated eye exam at least once a year to catch any problems early when treatment is most effective[24]"; and

Whereas, Various recent proposals from the executive and legislative branches have proposed the creation of additional benefits for routine eye exams under Medicare Part B, including President Biden's 2022 budget request, legislation (H.R. 33) introduced to the House of Representatives in 2023, and the Senate bill (S.842) introduced to the Senate also in 2023, which all show significant political interest in increasing insurance benefits for eye exams[25-27]; and

Whereas, By updating AMA policy H-25.990 to include eye examinations for those greater than 40 and who have chronic systemic conditions affecting eye disease development our AMA will be in line with current AAO guidelines[3,4]; therefore be it

RESOLVED, That our AMA amend policy H-25.990 "Eye Exams for the Elderly" by addition to read as follows**:**

> **Eye Exams for the Elderly <u>and Adults</u> H-25.990**
> Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients <u>and adults who suffer from chronic systemic conditions that increase their likelihood of developing eye disease as well as a baseline eye examination for all adults aged 40 and above</u>; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings<u>; and (3) supports coverage benefits in public and private health plans for a baseline eye examination in adults aged 40 or above.</u>

Fiscal Note: Minimal

REFERENCES:

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RELEVANT AMA POLICY:

AMA Endorsement of Screening Tests or Standards G-600.064
(1) Delegates, state, or specialty societies submitting a resolution seeking endorsement or AMA adoption of specific screening tests must also submit an evidence-based review that determines the strength or quality of the evidence supporting their request, and that evaluates the degree to which the test satisfies the minimal criteria for validating the appropriateness of the screening test, which are: (a) the test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false-positive and false-negative results; and (b) screening for and treating persons with early disease should improve the likelihood of favorable health outcomes compared with treating patients when they present with signs or symptoms of disease. (2) This review will be made available to the reference committee, which will either recommend to the House of Delegates that the resolution be referred or not be adopted. Citation: [CSA Rep. 7, A-02CC&B Rep. 3, I-08 Reaffirmed: CCB/CLRPD Rep. 3, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22]

Early and Periodic Screening, Diagnosis, and Treatment D-290.987
Our AMA recognizes the importance of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and will advocate for EPSDT to remain intact as critical to the health and well-being of children. Citation: [Res. 708, I-05 Modified: CMS Rep. 1, A-15]

Insurance Coverage of Periodic Health Care Services H-185.965
Our AMA adopts the policy that patients should be able to receive insurance coverage for periodic services performed within an appropriately flexible interval (i.e., once annually, rather than having to wait precisely 365 days). Citation: [Res. 128, A-99 Reaffirmed: CMS Rep. 5, A-09 Modified: Sub. Res. 811, I-10Reaffirmed: CMS Rep. 01, A-20]

Eye Exams for the Elderly H-25.990
Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. Citation: [Res. 813, I-05 Reaffirmed: CSAPH Rep. 1, A-15]

Encouraging Vision Screenings for Schoolchildren H-425.977
Our AMA: (1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment; (2) encourages the development of programs to improve school readiness by detecting undiagnosed vision problems; and (3) supports periodic pediatric eye screenings based on evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate. Citation: [Res. 430, A-05Modified: CSAPH Rep. 1, A-15]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 4
(I-23)

Introduced by: Antranik Dabaghian, MD

Subject: Enhancing Dermatopathology Training for Pathology Residents

Referred to: Reference Committee

Whereas, Dermatopathology is a vital subspecialty that bridges dermatology and pathology, providing essential diagnoses for a wide array of skin diseases and conditions[1]; and

Whereas, The increased incidence of skin-related disorders, including skin cancers[2], demands thorough training in dermatopathology for pathology residents; and

Whereas, Consistent and enhanced training in dermatopathology can better equip pathology residents in their future practices and improve patient care; and

Whereas, Many pathology residency programs offer limited exposure to dermatopathology, which may not adequately prepare residents for real-world challenges; therefore be it

RESOLVED, That our AMA advocate for the standardization of dermatopathology training across pathology residency programs in the US, ensuring comprehensive exposure and education; and be it further

RESOLVED, That our AMA work with the American Society of Dermatopathology and other relevant stakeholders to develop guidelines and resources that support this enhanced training initiative.

Fiscal Note: Moderate

References:

1. "Dermatopathology." *College of American Pathologists*, www.cap.org/member-resources/pathology-careers/pathology-subspecialties/dermatopathology.
2. "Radiation: Ultraviolet (UV) Radiation and Skin Cancer." *World Health Organization*, World Health Organization, 16 Oct. 2017, www.who.int/news-room/questions-and-answers/item/radiation-ultraviolet-(uv)-radiation-and-skin-cancer.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 5
(I-23)

Introduced by: Mustfa Manzur, MD, MPH, MS; Catherine Iyoha-Idiong, MB, ChB; Riddhi Modi, OMS-II

Subject: Recognizing Moral Injury in Medicine as a Phenomenon Distinct from Burnout

Referred to: Reference Committee

Whereas, The suicide mortality likelihood for female physicians is more than twice than that of a non-physician female[1]; and

Whereas, The suicide mortality likelihood for male physicians is nearly 40% higher than that of a non-physician male[1]; and

Whereas, Suicidal ideation amongst medical students has been observed with an annual estimated prevalence of 24.2%[1]; and

Whereas, Approximately 300-400 physician suicides occur annually, equivalent to losing two classes worth of medical students per year[2]; and

Whereas, Burnout is recognized as a longstanding stress reaction characterized by emotional, exhaustion and lack of accomplishment and satisfaction in the work setting[3]; and

Whereas, Moral injury is a different but interrelated concept with burnout; and

Whereas, Moral injury in healthcare is defined as distress experienced when meeting the demands of administration, insurance, and government agencies that oppose the ethical values of medicine[3]; and

Whereas, Moral injury in healthcare is further defined as a psychological experience as a result of the intricate balance of a clinician doing what they perceive is right and the constraints of healthcare regulating, funding, and providing institutions, leading to violation of one's personal and professional moral framework that can directly lead to physician suicide[4]; and

Whereas, Current practices to combat burnout rely on utilizing yoga, meditative techniques, and pizza parties to remediate physician burnout, yet do not address the very institutions which create the framework of business practices in medicine that can force physicians into decision making that can be less optimal for delivering patient care and lead to moral injury[4]; therefore be it

RESOLVED, That our AMA study the issue of moral injury in medicine as a phenomenon distinct from burnout; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the 2023 Interim Meeting.

Fiscal Note: Minimal

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Relevant RFS Position Statements:

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

291.015R Intern and Resident Burnout: That our AMA-RFS support studying resident burnout to determine: (1) if recommendations can be made on how to recognize burnout, how to treat it, and, if possible, how to prevent it; (2) if it relates to the professionalism core competency for residents; and (3) if recognizing, treating, and possibly preventing burnout could be included in the program requirements for residency program directors. (Resolution 3, A-06) (Reaffirmed Report D, I-16)

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

Relevant AMA Policy:

Physician and Medical Student Burnout D-310.968
1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.
2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.
3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.
4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.
5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.
6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.
7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.

8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.
9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practices settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being. Citation: [CME Rep. 8, A-07 Modified: Res. 919, I-11 Modified: BOT Rep. 15, A-19 Reaffirmation: A-22]

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

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

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 6
(I-23)

Introduced by: Ian Brodka, MD; Whitney Sambhariya, MD, PhD

Subject: Improved Monitoring and Surveillance of Cadaveric Human Bone Tissue Products

Referred to: Reference Committee

Whereas, In the United States the Food and Drug Administration (FDA) regulates medicinal drugs and interventions in order to maintain safety and efficacy[1]; and

Whereas, the FDA policy Eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps) describes relevant communicable disease that should be tested for prior to transplantation to ensure the safety of the recipient[2]; and

Whereas, these products are defined as "articles containing or consisting of human cells or tissues that are intended for implantation, transplantation, infusion, or transfer into a human recipient" and include, but are not limited to "bone, ligament, skin, dura mater, heart valve, cornea, hematopoietic stem/progenitor cells derived from peripheral and cord blood, manipulated autologous chondrocytes, epithelial cells on a synthetic matrix, and semen or other reproductive tissue"[2];and

Whereas, Bone graft products, categorized as HCT/Ps, are used in orthopedic surgeries to expedite healing, but are not thoroughly researched with limited human studies of safety or efficacy[3]; and

Whereas, Donation procedures for HCT/Ps only require donors to only be tested for Human Immunodeficiency Virus, Hepatitis B Virus, Hepatitis C Virus, *Treponema pallidum*, West Nile Virus, Human T-Lymphotrophic Virus, Cytomegalovirus, *Chlamydia trachomatis*, and *Neisseria gonnorhea*[4]; and

Whereas, The FDA chose to test for these diseases because of previous transmission through cell and tissue material of the diseases to donors[5]; and

Whereas, Other diseases such as *Mycobacterium tuberculosis* (TB) are not currently required to be tested for prior to tissue or cell transplant leaving a possibility of transmission of these diseases to the new donor, which has occurred[6,7]; and

Whereas, Latent TB affects 25% of the world population and 4% of the United States population and the FDA has no current donor screening test available for HCT/P donors[8]; and

Whereas**,** There is currently an ongoing outbreak of TB directly associated with a HCT/P product, "ViBone", that has already resulted in the deaths of two people and was used in 36 total people prior to being recalled[6]; and

Whereas, In 2021 a different bone cell product in the same category, “FiberCel”, was sourced from an individual with unrecognized TB risk factors and symptoms and used in 117 people causing 87 confirmed TB infections and 8 deaths[7]; and

Whereas, TB has been reported to be transmitted through human bone, heart valve, and dura mater transplant demonstrating this problem goes beyond bone grafts[6,7,9,10]; and

Whereas**,** Inadequate surveillance and screening have contributed to these outbreaks and the FDA and Centers for Disease Control and Prevention are currently working to investigate the most recent outbreaks[8]; and

Whereas, The FDA has created recommendations for routine screening measures that can prevent further TB outbreaks, however, these have not become a part of their official policy for donor screening[8]; and

Whereas, On January 30th, 2023, the FDA Center on Biologics announced it would be updating relevant policy for infectious disease screening in HCT/Ps within the next year meaning advocating for change now is important[11]; and

Whereas, Our AMA has no current policy on the surveillance and testing of human cell, tissue, and cellular and tissue-based products to maintain safety standards; and

Whereas, the Orthopedic surgery society does not have a position statement about this outbreak; and therefore be it

RESOLVED, That our AMA support the use of the US Food and Drug Administration's (FDA) risk mitigation strategies in all bone graft transplants; and be it further

RESOLVED, That our AMA support the inclusion of Mycobacterium tuberculosis (TB) testing and surveillance in the eligibility Determination for Donors of Human Cells, Tissues, and Cellular and Tissue-Based Products (HCT/Ps); and be it further

RESOLVED, That our AMA support the change in TB testing and surveillance for HCT/Ps by submitting a letter on the issue to the FDA; and be it further

RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates at the 2023 Interim Meeting.

Fiscal Note: Minimal

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RELEVANT AMA POLICY:

Regulation of Tissue Banking H-370.988
Our AMA: (1) supports the Food and Drug Administration's (FDA) proposed regulatory agenda for tissue banking organizations, and urges the FDA to continue working with nationally-recognized tissue banking organizations and other appropriate groups to implement the proposed oversight system; (2) promotes the adoption of the standards for tissue retrieval and processing established by nationally recognized tissue banking organizations that would mandate adherence to specific standards as a condition of licensure and certification for tissues banks; (3) supports FDA registration of all tissue banks; and (4) supports the continued involvement of the medical community in the further effort to ensure the safety and efficacy of the nation's supply of tissues. Citation: [BOT Rep. E, I-89Reaffirmed: Sunset Report, A-00; Modified and Appended, CSA Rep. 5, I-01; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17]

Blood and Tissue Donor Deferral Criteria H-50.973
Our AMA: (1) supports the use of rational, scientifically-based deferral periods for donation of blood, corneas, and other tissues that are fairly and consistently applied to donors according to their individual risk; (2) opposes all policies on deferral of blood and tissue donations that are not based on evidence; (3) supports a blood and tissue donation deferral period for those determined to be at risk for transmission of HIV that is representative of current HIV testing technology; (4) supports research into individual risk assessment criteria for blood and tissue donation; and (5) will continue to lobby the United States Food and Drug Administration to use modern medical knowledge to revise its decades-old deferral criteria for MSM (men who have sex with men) donors of corneas and other tissues. Citation: [Res. 514, A-13; Modified: Res. 008, I-16; Modified: Res. 522, A-19; Modified: Res. 510, A-22]

Multiple-Drug Resistant Tuberculosis - A Multifaceted Problem H-440.938
(1) Testing for tuberculous infection should be performed routinely on all HIV-infected patients, according to current recommendations from the U.S. Public Health Service. (2) Testing for HIV infection should be routinely performed on all persons with active tuberculosis. (3) Reporting of HIV infection and tuberculosis should be linked to enhance appropriate medical management and epidemiologic surveillance. (4) Aggressive contact tracing should be pursued for cases of active tuberculosis, especially if HIV-infected contacts or multiple-drug resistant tuberculosis strains have been involved. (5) HIV-infected health care workers and their physicians must be aware of the high risk of clinical TB for persons whose immune systems are compromised, due to HIV or other causes. They should be carefully apprised of their risk, and the risks and benefits of their caring for persons with active TB or suspected TB should be carefully considered. (6) HIV-infected and other immunocompromised patients should be sufficiently separated from tuberculosis patients and the air they breathe so that transmission of infection is unlikely. (7) All health care workers should have a tuberculin skin test upon employment, with the frequency of retesting determined by the prevalence of the disease in the community. Individuals with a positive skin test should be evaluated and managed according to current public health service recommendations. (8) Health care facilities that treat patients with tuberculosis should rigorously adhere to published public health service guidelines for preventing the nosocomial transmission of tuberculosis. (9) Adequate and safe facilities must be available for the care of patients with tuberculosis; in some areas this may necessitate the establishment of sanitariums or other regional centers of excellence in tuberculosis treatment. (10) Clinical tuberculosis laboratories should develop the capability of reliably performing or having reliably performed for them rapid identification and drug susceptibility tests for tuberculosis. (11) Routinely, drug

susceptibility tests should be performed on isolates from patients with active tuberculosis as soon as possible. (12) A program of directly observed therapy for tuberculosis should be implemented when patient compliance is a problem. (13) The AMA should enlist the aid of the Pharmaceutical Research and Manufacturers of America (PhRMA) in encouraging manufacturers to develop new drugs and vaccines for tuberculosis. (14) The federal government should increase funding significantly for tuberculosis control and research to curtail the further spread of tuberculosis and encourage development of new and effective diagnostics, drug therapies, and vaccines. (15) The special attention of physicians, public health authorities, and funding sources should be directed toward high risk and high incidence populations such as the homeless, immigrants, minorities, health care workers in high risk environments, prisoners, children, adolescents, and pregnant women. (16) The AMA will develop educational materials for physicians that will include but not be limited to the subtleties of testing for TB in HIV-infected individuals; potential risk to HIV-infected individuals exposed to infectious diseases, including TB; and other issues identified in this report. (17) The AMA encourages physicians to remain informed about advances in the treatment of tuberculosis, including the availability of combination forms of drugs, that may reduce the emergence of drug-resistant strains. Citation: [BOT Rep. OO, A-92; Sub. Res. 505, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 7
(I-23)

Introduced by: Toni-Ann Lewis MD; Alyssa Shannon, MD; Shane Sloger, MD; Sarah Goldhill, MD

Subject: Pregnancy and Parental Leave for Trainees

Referred to: Reference Committee

Whereas, Paid parental leave (maternal and paternal leave) reduces infant mortality and improves parental mental and physical health[1, 2]; and

Whereas, Paid parental leave increases the likelihood and duration of breastfeeding, increases rates of immunizations, and increases regularity of well-baby checks[3, 4]; and

Whereas, Paid parental leave (maternal and paternal leave) has long-lasting positive impacts on children, including decreasing rates of ADHD, overweight status, and hearing-related problems[5]; and

Whereas, Parental leave (maternal and paternal leave) does not negatively impact the performance of medical/surgical trainees on board scores, work published, procedures performed, or patient satisfaction[6, 7]; and

Whereas, Rotating shifts between days and nights and working long hours increases the odds of preterm delivery, preeclampsia, gestational hypertension, and infant small for gestational age[8, 9, 10]; and

Whereas, night shifts are associated with early spontaneous pregnancy loss, preterm delivery, and miscarriage[8, 9, 15]; and

Whereas, prolonged standing increases the odds of preterm delivery[11, 12]; and

Whereas, the Accreditation Council for Graduate Medical Education (ACGME) allows for 12 weeks of leave, other than vacation, without needing to extend residency, American Board of Internal Medicine (ABIM) allows 105 days absent from residency, including vacation, with the opportunity of a further 35 days (total 7 weeks)[13,14]; and

Whereas, The ACGME recently clarified that the ACGME Institutional Review Committee will not take enforcement actions against Sponsoring Institutions pertaining to the new requirements until after July 1, 2023 although, the requirements went into effect July 1, 2022, in order to make time for Sponsoring Institutions to develop and implement new leave policies and align their existing leave framework with the new requirements[18]; and

Whereas, Parental leave (maternity and paternity leave) has been inconsistently applied throughout different training programs; therefore be it

RESOLVED, That our AMA support reasonable accommodations during pregnancy, agreeably defined by the trainee and their program director; and be it further

RESOLVED, That our AMA encourage training programs to create a standard practical accommodation form to be filled out within the first trimester; and be it further

RESOLVED, That our AMA support that standard practical accommodations include the option to defer night shift work in the 1st or 3rd trimester, less physically demanding rotations while in the 3rd trimester of pregnancy, and time off for scheduled medical appointments without having to use vacation time, elective blocks, or sick leave; and be it further

RESOLVED, That our AMA amend Policies for Parental, Family and Medical Necessity Leave H-405.960 and Residents and Fellows' Bill of Rights H-310.912 to encourage residency and fellowship programs to allow trainees to take 12 weeks of fully paid parental leave (maternity and paternity leave) without having to use vacation time, elective blocks, or sick leave; and be it further

RESOLVED, That our AMA support the option for 12 weeks of parental leave (maternity and paternity leave) to be taken once during a given training program's duration without delaying the ability to take board exams or graduation; and be it further

RESOLVED, That our AMA encourage the ACGME and other relevant accreditation bodies to have the same leave requirements in order to allow trainees to remain eligible to take their board exams and graduate in their expected timeframe; and be it further

RESOLVED, That our AMA Council on Medical Education create standardized policy language to act as a resource for program directors and trainees in the creation of program-specific policy to ensure fair and uniform treatment of trainees regarding parental leave and pregnant trainees.

Fiscal note: Moderate

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RELEVANT RFS POSITION STATEMENTS:

140.101R Preserving Access to Reproductive Health Services: That our AMA-RFS support our AMA: (1) Recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) Opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) Will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) Supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) Opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) Opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) Will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; (8) Will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at I-22. (Late Resolution 1, A-22)

RELEVANT AMA POLICY:

Policies for Parental, Family and Medical Necessity Leave H-405.960
AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA will study the impact on and feasibility of medical schools, residency programs, specialty boards, and medical group practices incorporating into their parental leave policies a 12-week minimum leave allowance, with the understanding that no parent be required to take a minimum leave.
5. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed.
6. Residency program directors should review federal and state law for guidance in developing policies

for parental, family, and medical leave.
7. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
8. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) duration of leave allowed after abortion or stillbirth; (d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (e) whether leave is paid or unpaid; (f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (g) whether sick leave and vacation time may be accrued from year to year or used in advance; (h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (i) how time can be made up in order for a resident physician to be considered board eligible; (j) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (k) whether time spent in making up a leave will be paid; and (l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
9. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
10. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
11. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
12. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
13. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
14. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
15. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
16. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
17. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
18. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship. [CCB/CLRPD Rep. 4, A-13 Modified: Res. 305, A-14 Modified: Res. 904, I-14 Modified: Res. 307, A-22 Modified: Res. 302, I-22 Modified: Res. 312, I-22]

Compassionate Leave for Medical Students and Physicians H-405.947
Our AMA urges medical schools, **residency** and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of compassionate leave policies as part of the physician's standard benefit agreement.
Our AMA will study components of compassionate leave policies for medical students and physicians to include:
a. whether cases requiring extensive travel qualify for additional days of leave and, if so, how many days;
b. policy and duration of leave for an event impacting pregnancy or fertility including pregnancy loss, an unsuccessful round of intrauterine insemination or of an assisted reproductive technology procedure, a failed adoption arrangement, a failed surrogacy arrangement, or an event that impacts pregnancy or fertility; c. whether leave is paid or unpaid;
d. whether obligations and time must be made up; and
e. whether make-up time will be paid.
3. Our AMA encourages medical schools, residency and fellowship programs, specialty boards, specialty societies and medical group practices to incorporate into their compassionate leave policies a three-day minimum leave, with the understanding that no medical student or physician should be required to take a minimum leave.
4. Medical students and physicians who are unable to work beyond the defined compassionate leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution s sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons.
5. Our AMA will study the concept of equal compassionate leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity.
6. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
7. These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship. [Res. 309, I-22]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 8
(I-23)

Introduced by: Emma York, DO; Daniel Lee, MD; Michael Visenio, MD

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

Referred to: Reference Committee

Whereas, Medical resident and fellow physicians contribute significantly to patient care, often serving as the main point of contact; and

Whereas, When a residency or fellowship program closes, the health system often hires more than twice the number of advanced practice providers (APPs) to replace the equivalent work of resident and fellow physicians[1]; and

Whereas, In comparison to APPs in the same market, resident and fellow physicians receive significantly less pay while working in the same field[2,3]; and

Whereas, In recent unionization efforts, resident and fellow physicians have to prove their worth to negotiate for better benefits with their health system; and

Whereas, Our AMA supports appropriate increases in resident physician salaries (Policy H-305.930), however, trainees frequently feel as if they lack substantial grounds or collective bargaining to advocate for improved work conditions and benefits; and

Whereas, Our AMA supports increased transparency around physician salaries as well as in healthcare in general (Policies H-385.906, H-510-980, H-110.991); and

Whereas, Our AMA supports developing a system to best help resident physicians in navigating negotiation practices (Policy D383.996); therefore be it

RESOLVED, That our AMA advocate for increased transparency of revenue generated for health systems by resident and fellow physicians; and it be further

RESOLVED, That our AMA work with relevant stakeholders to require health systems to report revenue generated by care associated with resident and fellow physicians in the form of a publicly-accessible annual report.

Fiscal Note: Modest

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1. White, Ben. “The Resident to Midlevel Ratio: Ben White.” *Ben White | Medicine & Miscellany*, 11 Feb. 2022, www.benwhite.com/medicine/the-resident-to-midlevel-ratio/.
2. *Physician Assistant - Career Rankings, Salary, Reviews and Advice | US ...*, US News, money.usnews.com/careers/best-jobs/physician-assistant. Accessed 25 Sept. 2023.
3. “Medical Residency Salary by Specialty 2021.” *MedEdits*, 17 Aug. 2023, mededits.com/residency-admissions/residency-salary/.

RELEVANT AMA POLICY:

Residents' Salaries H-305.930: Our AMA supports appropriate increases in resident salaries. Citation: [Res. 307, A-05. Reaffirmed: CME Rep. 1, A-15, Reaffirmed in lieu of: Res. 307, I-22]

AMA Resources, Advocacy, and Leadership Efforts to Secure Labor Protections for Physicians in Training D-383.996: Our AMA: (1) representatives to the ACGME be encouraged to ask the ACGME to review the Institutional Requirements and make recommendations for revisions to address issues related to the potential for resident physicians to be members of labor organizations. This is particularly important as it relates to the section on Resident Support, Benefits, and Conditions of Employment; and (2) through the Division of Graduate Medical Education, the Resident and Fellow Section, and the Private Sector Advocacy Group develop a system to inform resident physicians, housestaff organizations, and employers regarding best practices in labor organizations and negotiations. Citation: [CME Rep. 7, A-00, Reaffirmed: CME Rep. 2, A-10, Reaffirmed CME Rep.01, A-20, Modified: Speakers Rep., A-22]

Addressing the Racial Pay Gap in Medicine H-385.906: Our AMA will work with appropriate stakeholders to study effective and appropriate measures to increase the transparency and accountability of physician earnings through establishing transparency measures, in which physicians can access information including but not limited to the salaries and race of medical physicians. Citation: [Res. 07, I-19]

Promoting Salary Transparency Among Veterans Health Administration Employed Physicians H-510.980: Our AMA encourages physician salary transparency within the Veterans Health Administration. Citation: [Res. 217, I-19]

Price of Medicine H-110.991: Our AMA work with relevant organizations to advocate for increased **transparency** through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare’s drug-pricing dashboard. Citation: [CMS Rep. 6, A-03, Appended: Res. 107, A-07, Reaffirmed in lieu of: Res. 207, A-17]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 9
(I-23)

Introduced by: Emma York, DO

Subject: Decreasing Osteopathic Bias in Residency and Fellowship Applications

Referred to: Reference Committee

Whereas, Our AMA recognizes both the United States Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) examinations to be stringently validated psychometric examinations; and

Whereas, COMLEX-USA is a licensing exam for osteopathic physicians, and COMLEX-USA Levels 1 and 2 are required for osteopathic medical students to graduate from medical school and apply to ACGME residency programs; and

Whereas, Many osteopathic medical students continue to take USMLE Step 1 and 2 in addition to their required COMLEX-USA Level 1 and 2 exams due to fear of prejudice while applying to ACGME residency programs; and

Whereas, The cost of taking all four USMLE and COMLEX-USA exams during medical school is currently $3,430 ($1,000 each for USMLE Step 1 and Step 2; $715 each for COMLEX-USA Level 1 and Level 2)[1,2]; and

Whereas, Students have previously stated their objection to taking both the USMLE and COMLEX-USA examinations due to the financial, time and stress burdens of taking multiple exams (AMA Policy D-275.947); and

Whereas, Filters such as those for examination scores and school attended can be used to exclude applicants from review for residency positions; and

Whereas, When residency program directors have been surveyed, USMLE Step 2 scores were noted to be the number one utilized filter when screening applications[3]; and

Whereas, Applications of osteopathic medical students who choose not to take USMLE exams due to cost or other factors may screened out based on this filtering process; and

Whereas, Discriminatory use of filters employed by the Electronic Residency Application Service® (ERAS) have been a topic of conversation for a number of years (AMA policies H-295.876, H-255.963); and

Whereas, In 2022, the use of ERAS filters was deemed to be an unfair obstacle to select groups, such as the international medical graduates (AMA Policy H-255.963); and

Whereas, Osteopathic medical students face similar barriers as a consequence of ERAS filters; and

Whereas, Level 1 and Step 1 are presently pass/fail, input of a pass/fail mark or utilizing percentile scores (for Level 2 and Step 2) instead of arbitrary numerical value input would eliminate causes for discrimination, thus aligning with current AMA policies (AMA Policy H-275.953); and

Whereas, Scores are currently input using the separate USMLE or the COMLEX-USA scoring systems, making comparisons between scores among applicants from allopathic and osteopathic schools difficult for program directors; and

Whereas, If equitable score input was instrumented in the residency application process, it would result in a fair and balanced application process for all prospective residents; and

Whereas, Our AMA continues to support equal treatment of osteopathic students, trainees, and physicians in the clinical rotation, residency application cycle and workplace through continued education on the training of osteopathic physicians (AMA Policy H-295.848); and

Whereas, Our AMA discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training (AMA Policy H-295.876); and

Whereas, The American Osteopathic Association (AOA) supports public policy solutions that assure universal acceptance of applications from qualified osteopathic medical students and universal acceptance of COMLEX-USA when a test score is required by a GME program; therefore be it

RESOLVED, That our AMA work with the American Osteopathic Association (AOA) and other relevant stakeholders to advocate for the implementation of a system of equitable score input that reflects the equivalency of United States Medical Licensing Exam (USMLE) and Comprehensive Osteopathic Medical Licensing Exam of the United States (COMLEX-USA) examinations in residency and fellowship applications.

Fiscal Note: Minimal

REFERENCES:

1. ECFMG. “Fee Increases Effective January 1, 2023.” *ECFMG*, 23 Dec. 2022, www.ecfmg.org/news/2022/12/23/fee-increases-effective-january-1-2023/.
2. NBOME. “Fees.” *NBOME*, www.nbome.org/assessments/comvex/fees/. Accessed 24 Sept. 2023.
3. Garber AM, Kwan B, Williams CM, Angus SV, Vu TR, Hollon M, Muntz M, Weissman A, Pereira A. Use of Filters for Residency Application Review: Results From the Internal Medicine In-Training Examination Program Director Survey. J Grad Med Educ. 2019 Dec;11(6):704-707. doi: 10.4300/JGME-D-19-00345.1. PMID: 31871573; PMCID: PMC6919169.

RELEVANT AMA POLICY:

Single Licensing Exam Series for Osteopathic and Allopathic Medical Students D-275.947: Our AMA will work with key stakeholders to encourage the development of a single licensing examination series for all medical students attending a medical school accredited by the Liaison Committee on Medical Education (LCME) or the Commission on Osteopathic College Accreditation (COCA), with a separate, additional osteopathic-specific subject test for osteopathic medical students. Citation: [Res 325, A-22]

Equal Fees for Osteopathic and Allopathic Medical Students H-295.876: 1. Our AMA, in collaboration with the American Osteopathic Association, discourages discrimination against medical students by institutions and programs based on osteopathic or allopathic training. Citation: [Res. 809, I05 Appended:

CME Rep. 6, A-07 Modified: CCB/CLRPD Rep. 2, A-14 Appended: Res 303, I-19 Modified CME Rep. 5, I-21 Modified: CME Rep. 1, A-22]

Filtering International Medical Graduates During Residency or Fellowship Applications H-255.963:
1. Our American Medical Association recognizes the exclusion of certain residency applicants from consideration, such as international medical graduates.
2. Our AMA opposes discriminatory use of filters designed to inequitably screen applicants, including international medical graduates, using the Electronic Residency Application Service® (ERAS®) system. Citation: [Res 313, A-23]

The Grading Policy for Medical Licensure Examinations H-275.953: […]3. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. 4. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores. Citation: [CME Rep. G, I-90 Reaffirmed by Res. 310, A-98, Reaffirmed: CME Rep. 3, A-04, Reaffirmed CME Rep. 2, A-14, Appended: Res. 309, A-17, Modified: Res. 318, A-18, Appended: Res. 955, I-18, Appended Res. 301, I-21, Modified: CME Rep. 1, A-22]

Teaching and Assessing Osteopathic Manipulative Medicine and Osteopathic Principles and Practice H-295.848: Our American Medical Association will continue to support equal treatment of osteopathic students, trainees, and physicians in the residency application cycle and workplace through continued education on the training of osteopathic physicians. Citation: [Res. 301, A-23]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution:10
(I-23)

Introduced by: Sophia Spadafore, MD; Karen Dionesotes, MD, MPH; Ariel Carpenter, MD; Celeste Peay, MD, JD; Dan Pfiefle, MD; Danielle Rivera, MD; Adam Roussas, MD

Subject: Amendment to AMA Policy on Healthcare System Reform Proposals

Referred to: Reference Committee

Whereas, Almost 100 million Americans are either uninsured or underinsured, leading to worse health outcomes via inadequate access to necessary healthcare and adverse financial outcomes including bankruptcy[1-5]; and

Whereas, America's fragmented and disorganized health insurance system places too much power in the hands of for-profit insurers who are strongly incentivized to erect barriers to adequate healthcare, leading to the proliferation of "utilization management" methods like prior authorization that delay or deny necessary care and contribute to physician burnout[6-13]; and

Whereas, Unified financing refers to any system of healthcare financing that provides uniform and universal access to healthcare coverage that is high quality and affordable, which can include single payer or multi-payer systems based on managed competition between private insurers[14-19], and does not necessarily mean "government run"; and

Whereas, The AMA staunchly opposed the creation of Medicare, and was therefore not included in its creation, leading to the decades of poor reimbursement and other issues we have with it today; and

Whereas, Ample evidence shows that single payer proposals, and other unified financing proposals based on other models, can be constructed that provide equitable, universal, and timely access to high quality care by simplifying our fragmented system and placing decision making power back in the hands of physicians and patients, but current oppositional AMA policy mandates opposition based on the label of single payer; therefore be it

RESOLVED, That our AMA-RFS support removal of opposition to single-payer healthcare delivery systems from AMA policy, and instead support evaluation of all healthcare system reform proposals based on our stated principles as in AMA policy; and be it further

RESOLVED, That our AMA-RFS support a national unified financing healthcare system that meets the principles of freedom of choice, freedom and sustainability of practice, and universal access to quality care for patients.

Fiscal Note: Minimal

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1. The state of U.S. Health Insurance in 2022. State of U.S. Health Insurance in 2022: Biennial Survey | Commonwealth Fund. September 29, 2022. Accessed September 25, 2023. https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey.
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3. http://medicine.tums.ac.ir/filegallery/2299016929/nezamoleslami%2031%20ordibehesht.pdf
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RELEVANT RFS POSITION STATEMENTS:

140.001R Health Care Reform Plan: That our AMA-RFS (1) continue to advocate for health system reform which makes health insurance coverage accessible for all U.S. citizens; (2) support requiring all children to have health insurance as a strategic priority; (3) advocate for sufficient federal subsidy or tax credit amounts so that all U.S. citizens can afford to purchase health insurance; (4) support the requirement for private insurers that children up to age 26 could continue family coverage through their parents' plan; (5) support working with the federal government to ensure that if federal programs are to be expanded, that proper checks and balances are in place to ensure that reimbursements reflect the actual cost of care and that patient access is not limited; and (6) support that under the National Health Insurance Exchange (or any similar proposed program) that participating insurers provide high quality, transparent services, and that their reimbursements reflect the actual cost of care. (Report H, I-08)

140.003R Health Care as a Right for All People: That our AMA-RFS assert that all people deserve access to quality, affordable, basic and preventative healthcare. (Substitute Resolution 11, A-07)

140.005R The Fundamental Importance of Universal Access: That our AMA-RFS: (1) strongly assert that the fundamental goal of any change in the American health care system should be to move toward increased access to quality health care for every American citizen; and (2) support access to high quality health care for all Americans as a clear guiding principle in evaluating and responding to proposals to change the American health care system. (Substitute Resolution 33, I-95) [See also: AMA Policy H165.918, H-165.969] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

140.006R Advocating for Patients and Health Care Reform: That our AMA-RFS support the principle that AMA negotiations with Congress on health system reform continue assigning priority to patient advocacy. (Substitute Resolution 29, I-95) [See also: AMA Policy H-320.954] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

140.007R AMA-RFS Participation in the AMA's Effort to Reevaluate the U.S. Health Care Delivery System: That our AMA-RFS: (1) Governing Council and representatives on AMA councils forcefully represent trainees and young physicians in the AMA's effort to reevaluate the U.S. health care system; and (2) prioritize maintaining and expanding AMA-RFS representation in the study of changes to the U.S. health care system. (Substitute Resolution 6, A-82) (Reaffirmed Report C, A-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

140.009R Healthcare Coverage and Access Proposals 2019: That our AMA-RFS support proposals that: (1) increase access to healthcare coverage across all ages and income levels, do not discriminate or limit coverage based on pre-existing conditions, and encompass comprehensive coverage of routine healthcare needs of patients including women's health and reproductive services, (2) cap premiums and limit cost sharing to a reasonable level; and (3) include adequate networks of providers and physician-led healthcare teams. (Report G, A-19)

RELEVANT AMA POLICY:

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and

administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
Citation: [Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93, Res. 130, I-93, Res. 316, I-93, Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep.1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09: Res. 101, A-09, Sub. Res. 110, A-09, Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17]

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: a. Health insurance coverage for all Americans; b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps; c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials; d. Investments and incentives for quality improvement and prevention and wellness initiatives; e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care; f. Implementation of medical liability reforms to reduce the cost of defensive medicine; g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
…

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
…

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
…

Citation: [Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 11
(I-23)

Introduced by: Dayna Isaacs, MD, MPH; Alexandria Wellman, MD, MS; Thomas Pak, MD, PhD

Subject: Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being

Referred to: Reference Committee

Whereas, United States Medical Licensing Examination (USMLE) Step 3 is the final licensure examination in the USMLE series for physician licensure, which is taken during residency training[1]; and

Whereas, Step 3 is a two-day examination, with the first day ("Foundations of Independent Practice," 7 hours of testing) focused on basic science principles and the second day ("Advanced Clinical Medicine," 9 hours of testing) focused on application of clinical knowledge; and

Whereas, The first testing day consists of multiple-choice questions and the second day consists of a combination of multiple-choice questions and computer-based case simulations[1]; and

Whereas, The cost of registering to take Step 3 is $915 in 2023, with an increase to $925 in 2024 and subsequent annual fee increases[2]; and

Whereas, The Step 3 test preparation question bank costs an individual resident $429 in 2023, which an increase for each renewal period; and

Whereas, Given that the computer-based simulation section utilizes software from a company called *Primum*, which differs drastically from the Electronic Medical Record, trainees often purchase CCS Cases to learn the software, which costs at minimum $70; and

Whereas, Therefore, the total cost of Step 3 preparation and examination is at least $1,400 per trainee, not including two missed days of work; and

Whereas, Trainees may have to use their designated days off to prepare for and to sit for the examination, exacerbating moral injury and burnout; and

Whereas, The objective of Step 3 is to test general medicine concepts primarily in an ambulatory setting, which does not accurately reflect the sub-specialization and complexity of modern-day medicine, and, therefore, does not justify a numerical score across disciplines; and

Whereas, Step 3 was designed for examination after successful completion of one's medical degree, however, USMLE recommends the completion of one post-graduate year of training[3]; and

Whereas, Specialty choice is highly predictive of examination score; trainees in general medicine fields (i.e. family medicine, emergency medicine, internal medicine, medicine-pediatrics, and pediatrics) obtain significantly higher scores on Step 3 compared to more specialized fields, supported by a retrospective study (n=36,805) of U.S. and Canadian medical school graduates who took Step 3 for the first time between 1999 and 2002[4]; and

Whereas, The National Board of Medical Examiners (NBME) published data from 275,392 board-certified physicians who passed Step 3 between 2000 and 2017, indicating that a higher score inversely correlated with likelihood of disciplinary action from the medical board. However, a limitation included treating all disciplinary actions equally, which does not translate directly to medical and/or surgical skills[5]; and

Whereas, There are no published data that correlate one's numeric Step 3 score with true clinical skills and beneficial patient outcomes; and

Whereas, Preparing for Step 3 on top of clinical duties during residency may detract from on-the-job learning and patient care, especially for trainees who pursue fellowships, as Step 3 scores are a component of the application process; and

Whereas, Residency programs do not give residents protected study time for Step 3, thus, residents must prepare for the examination on top of their 60-80+ hour work-weeks; and

Whereas, A one-day, pass/fail examination has the potential to reduce trainee costs, promote trainee well-being, and encourage more learning via patient care in lieu of question banks; therefore be it

RESOLVED, That our AMA supports a transformation of the United States Medical Licensing Examination (USMLE) Step 3 from a numerically-scored examination to a pass/fail examination; and be it further

RESOLED, That our AMA supports a transformation of UMSLE Step 3 from a two-day examination to a one-day examination; and be it further

RESOLVED, That our AMA supports the option to take USMLE Step 3 after passing Step 2-Clinical Knowledge (CK) during medical school.

Fiscal Note: Minimal

REFERENCES:

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4. "Eligibility." *USMLE*, www.usmle.org/bulletin-information/eligibility. Accessed 24 Sept. 2023.
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RELEVANT RFS POSITION STATEMENTS:

240.010R USMLE Step 3 and Initial Licensure Fees: That our AMA-RFS support: (1) that the total fees required when a resident registers for the USMLE Step 3, including any required licensure fees, be kept

at a moderate level; and (2) the AMA investigating the costs involved in administering the USMLE, including any future computerized version and encourage minimization of the costs to physicians in training. (Report G, A-98) (Reaffirmed Report D, I-16)

RELEVANT AMA POLICY:

Proposed Single Examination for Licensure H-275.962: Our AMA: (1) endorses the concept of a single examination for medical licensure; (2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination; (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and (6) will work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies. Citation: [CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 3, I-14; Appended: Res. 309, A-17]

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 12
(I-23)

Introduced by: Dayna Isaacs, MD, MPH; Russyan Mark Mabeza, MD, MPH; Faith Crittenden, MD, MPH; Whitney Stuard Sambhariya MD, PhD; Prachi Thapar, DO

Subject: Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine

Referred to: Reference Committee

Whereas, Founded in 1902, the Alpha Omega Alpha (AOA) Honor Medical Society consists of over 200,000 medical student and physician members across 135 chapters with a mission to recognize high educational achievement[1]; and

Whereas, AOA membership is disproportionately White. A 2017 cohort study of 4,655 medical students illustrated that AOA membership for White students was nearly 6 times greater than that for Black students and nearly 2 times greater than that for Asian students[2]; and

Whereas, Black medical students are significantly less likely to be inducted into AOA compared to other groups, according to a 2019 cohort study that examined data from 11,781 ERAS applications[3]; and

Whereas, Exclusion from AOA membership also disproportionately impacts Hispanic/Latino, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander students[4]; and

Whereas, These inequities are especially concerning given the differential access AOA membership affords; AOA members are prioritized for interview invites and have greater odds of matching into traditionally competitive specialties (i.e., dermatology, plastic surgery, orthopedic surgery, urology, radiation oncology, and otolaryngology)[5]; and

Whereas, According to AOA's website, 75% of medical school deans are AOA members, suggesting that membership can amplify success over the course of one's career; and

Whereas, Entry into AOA relies heavily upon clerkship grades, which are subject to significant biases. Studies show that students of color tend to receive lower clerkship grades compared to their White counterparts, particularly those who are underrepresented in medicine (UIM), even after controlling for test scores[4]; and

Whereas, In clinical evaluations, White medical students have a greater propensity to be characterized by their professional attributes such as "knowledgeable," while Black students are more likely to be described by personal characteristics like "pleasant[6];"

Whereas, UIM students undergo additional burden and energy expenditure that non-UIM students do not experience, such as activation via triggers, internal dialogue, and threat response, which may negatively impact their clerkship grades; and

Whereas, UIM students additionally face difficulty finding peer support networks, trouble establishing peer-working relationships, and experiences of racism while being expected to lead uncompensated diversity, equity, and inclusion efforts at their institutions, all of which can detract from academic and clinical duties; and

Whereas, Multiple institutions have disaffiliated from AOA due to racial inequities in membership, including the UCSF School of Medicine, the Yale School of Medicine, and the Icahn School of Medicine at Mount Sinai[7-9]; and

Whereas, in 2020, AOA evolved eligibility criteria to promote diversity by increasing the number of members per class and by allowing chapters to develop their own metrics, although this change has failed to address the structural issues perpetuated by AOA[10]; and

Whereas, Disaffiliation from AOA is a critical step toward promoting equity in admissions and medical education at large; and

Whereas, Disaffiliation from AOA entails eliminating institutional ties to the AOA national organization, and residency applicants select “no AOA chapter at my school” under the ERAS awards section; and

Whereas, Disaffiliation from AOA sends a compelling message that medical education needs alternative, equitable mechanisms to recognize the excellence of trainees; therefore be it

RESOLVED, That our AMA recognizes that the Alpha Omega Alpha Honor Medical Society disproportionately benefits privileged trainees while discriminating against trainees of color; and be it further

RESOLVED, That our AMA supports institutional disaffiliation from the Alpha Omega Alpha Honor Medical Society due to its perpetuation of racial inequities in medicine.

Fiscal Note: Minimal

REFERENCES:

1. AOA’s History. Alpha Omega Alpha Honor Medical Society. Accessed September 22, 2023. https://www.alphaomegaalpha.org/about/aoas-history/
2. Boatright D, Ross D, O’Connor P, Moore E, Nunez-Smith M. Racial disparities in medical student membership in the Alpha Omega Alpha Honor Society. *JAMA Internal Medicine*. 2017;177(5):659-665. doi:10.1001/jamainternmed.2016.9623
3. Wijesekera TP, Kim M, Moore EZ, Sorenson O, Ross DA. All other things being equal: exploring racial and gender disparities in medical school honor society induction. *Acad Med*. 2019;94(4):562-569. doi:10.1097/ACM.0000000000002463
4. Teherani A, Hauer KE, Fernandez A, King TE Jr, Lucey C. How small differences in assessed clinical performance amplify to large differences in grades and awards: a cascade with serious consequences for students underrepresented in medicine. *Acad Med*. 2018;93(9):1286-1292. doi:10.1097/ACM.0000000000002323
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7. UCSF School of Medicine suspends affiliation with Alpha Omega Alpha (AOA) Honor Society. University of California San Francisco School of Medicine. June 5, 2022. Accessed September 22, 2023. https://meded.ucsf.edu/news/ucsf-school-medicine-suspends-affiliation-alpha-omega-alpha-aoa-honor-society
8. Study finds socioeconomic disparities in AOA Honor Medical Society membership. Yale School of Medicine. June 2, 2021. Accessed September 22, 2023. https://medicine.yale.edu/news-article/study-finds-socioeconomic-disparities-in-awa-honor-medical-society-membership/
9. Lynch G, Holloway T, Muller D, Palermo AG. Suspending student selections to Alpha Omega Alpha Honor Medical Society: how one school is navigating the intersection of equity and wellness. Acad Med. 2020;95(5):700-703. doi:10.1097/ACM.0000000000003087

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 13
(I-23)

Introduced by: Karen Dionesotes, MD, MPH; Sophia Spadafore, MD; Luis Seija, MD

Subject: Studying Avenues for Parity in Mental Health & Substance Use Coverage

Referred to: Reference Committee

Whereas, The Mental Health Parity Act passed in 1996 and was the first law to impose any sort of parity between mental and physical health care, with an imposition on the annual or lifetime dollar limits on mental health benefits being any less favorable than those imposed on medical/surgical benefits[1]; and

Whereas, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 took this concept further by preventing group health plans and health insurance insurers from imposing less favorable benefit limitations for mental health or substance use disorder benefits than on medical/surgical benefits[1]; and

Whereas, Prior to and since the inception of these federal laws, our AMA has been advocating for parity in insurance benefits for those receiving mental health and substance use care (H-185.974, H-168.888); and

Whereas, Despite violations being found in every investigation of insurance companies, as well as multiple AMA policies supporting parity and calling for compliance with parity laws (D-180.998, H-185.916, H-185.974), parity still does not exist and health plans are not remotely close to following parity laws regarding mental health/substance use benefits[2,3]; and

Whereas, Both the 2022 DOL/HHS/IRS Report to Congress & July 2023 MHPAEA Comparative Analysis Report to Congress showed widespread violations and repeated failure of health plans to provide sufficient, accurate information to regulators to perform the comparative analyses required by law[2,3]; and

Whereas, A 2023 Robert Wood Johnson Foundation Report found that cost-sharing was decreased for mental health when compared to primary care visits, such that 17% of plans required that a deductible be satisfied for mental health visits but not primary care visits, and that despite reporting these deficits year after year, they remain unchanged[4,5]; and

Whereas, In Georgia, 24 health plans provided no information to the state Department of Insurance to perform its statutorily-required comparative analyses and of the 28 plans that did submit information, none submitted sufficient information for the DOI to perform the comparative analyses[6]; and

Whereas, Lack of compliance is both federal as well as at the state level, without significant consequences including continuing to allow insurer participation in state-delivered insurance plans[6]; therefore be it

RESOLVED, That our AMA study the potential consequences to insurers for not complying with mental health and substance use parity laws, including but not limited to not being able to participate in state-delivered insurance plans.

Fiscal Note: Modest

REFERENCES:

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6. Jordan Sieder J. Georgia insurance companies flout mental health parity reporting requirements. State Affairs. September 8, 2023. Accessed September 25, 2023. https://stateaffairs.com/georgia/healthcare/georgia-insurance-companies-flout-mental-health-parity-reporting-requirements/.

RELEVANT RFS POSITION STATEMENTS:

250.002R Carve-outs and Discrimination in Managed Mental Health Care: That our AMA-RFS support payors eliminating mental health and chemical dependency carve-outs so that benefits for mental health and chemical dependency are managed and administered like other health care services. (Resolution 5, I-00) (Reaffirmed Report C, I-10)

RELEVANT AMA POLICY:

Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care H-185.916
Our AMA supports requirements of all health insurance plans to implement a compliance program to demonstrate compliance with state and federal mental health parity laws. Citation: [Res. 216, I-22]

Parity for Mental Health and Substance Use Disorders in Health Insurance Programs H-185.974
1. Our AMA supports parity of coverage for mental, health, and substance use disorders.
2. Our AMA supports federal legislation, standards, policies, and funding that enforce and expand the parity and non-discrimination protections of the Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C and D).
3. Our AMA supports federal legislation, standards, policies, and funding that require Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance use disorder care, consistent with nationally recognized medical professional organization level of care criteria for mental health or substance use disorders. Citation: [Res. 212, A-96, Reaffirmation A-97, Reaffirmed: Res. 215, I-98, Reaffirmation A-99, Reaffirmed: BOT Action in response to referred for decision Res. 612, I-99, Reaffirmation A-00, Reaffirmed: CMS Rep. 9, A-01, Reaffirmation A-02, Reaffirmation I-03, Modified: CMS Rep. 2, A-08, Reaffirmed: CMS Rep. 5, I-12, Reaffirmed in lieu of Res. 804, I-13, Reaffirmation A-15, Modified: Res. 113, A-16, Modified: Res. 216, I-22]

Insurance Parity for Mental Health and Psychiatry D-180.998
Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to

promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. Citation: [Res. 215, I-98, Reaffirmation I-03, Reaffirmed in lieu of Res. 910, I-06, Reaffirmation A-15]

Maintaining Mental Health Services by States H-345.975
Our AMA:
1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.
Citation: [Res. 116, A-12, Reaffirmation A-15, Reaffirmed: Res. 414, A-22]

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
Citation: [Res. 118, I-91, Res. 102, I-92, BOT Rep. NN, I-92, BOT Rep. S, A-93, Reaffirmed: Res. 135, A-93, Reaffirmed: BOT Reps. 25 and 40, I-93, Reaffirmed in lieu of Res. 714, I-93, Res. 130, I-93, Res. 316, I-93, Sub. Res. 718, I-93, Reaffirmed: CMS Rep. 5, I-93, Res. 124, A-94, Reaffirmed by BOT Rep.1- I-94,

CEJA Rep. 3, A-95, Reaffirmed: BOT Rep. 34, I-95, Reaffirmation A-00, Reaffirmation A-01, Reaffirmed: CMS Rep. 10, A-03, Reaffirmed: CME Rep. 2, A-03, Reaffirmed and Modified: CMS Rep. 5, A-04, Reaffirmed with change in title: CEJA Rep. 2, A-05, Consolidated: CMS Rep. 7, I-05, Reaffirmation I-07, Reaffirmed in lieu of Res. 113, A-08, Reaffirmation A-09, Res. 101, A-09, Sub. Res. 110, A-09, Res. 123, A-09, Reaffirmed in lieu of Res. 120, A-12, Reaffirmation: A-17]