

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION (A-22)

Report of Reference Committee

Benjamin Meyer, MD, Chair

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

2 3 **RECOMMENDED FOR ADOPTION**

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5 1. Report E – AMA-RFS Sunset Mechanism (2012)
6
7 2. Resolution 6 – Elimination of Seasonal Time Changes and Establishment of
8 Permanent Standard Time
9

10 **RECOMMENDED FOR ADOPTION AS AMENDED**

- 11
12 3. Report A – The Shortage of Bedside Nurses and Intersection with Concerns in Nurse
13 Practitioner Training
14
15 4. Report B – Preserving Physician Leadership in Patient Care
16
17 5. Report C – Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction
18 Metrics in Physicians v. Other Health Professionals
19
20 6. Report D – Increasing Musculoskeletal Education in Primary Care Specialties and
21 Medical School Education through Inclusion of Osteopathic Manual Therapy
22 Education
23
24 7. Resolution 2 – Assessing the Humanitarian Impact of Sanctions
25

26 **RECOMMENDED FOR ADOPTION IN LIEU OF**

- 27
28 8. Resolution 1 – Legalization of Fentanyl Test Strips
29 Resolution 4 – In Support of Drug Checking Services
30
31 9. Resolution 3 – Comprehensive Solutions for Medical School Graduates Who Are
32 Unmatched or Did Not Complete Training
33
34 10. Resolution 5 – The Criminalization of Medical Errors
35

36 **RECOMMENDED FOR REFERRAL**

- 37
38 11. Resolution 7 – Analysis of Antitrust Legislation Regarding the AAMC, ACGME,
39 NRMP, and other relevant Associations or Organizations

RECOMMENDED FOR ADOPTION

(1) REPORT E – SUNSET MECHANISM (2012)

RECOMMENDATION:

Recommendation in Report E be adopted and the remainder of the Report be filed.

The Sunset Mechanism 2012 RFS Positions contains a list of recommended actions regarding internal position statements last reviewed from the RFS 2012 fiscal year. Positions considered outmoded, irrelevant, duplicative, and inconsistent with more current positions will have specific recommendations. For each internal position statement under review, this sunset report recommends to: (1) rescind, (2) reaffirm, (3) reconcile with more recent actions, or (4) reaffirm with editorial changes, which constitutes a first order motion.

Your Reference Committee heard only supportive testimony and recommends Report E be adopted and the remainder of the report be filed.

(2) RESOLUTION 6 – ELIMINATION OF SEASONAL TIME CHANGES AND ESTABLISHMENT OF PERMANENT STANDARD TIME

RECOMMENDATION:

Resolution 6 be adopted.

RESOLVED, That our AMA supports the elimination of seasonal time changes; and be it further

RESOLVED, That our AMA supports the adoption of year-round standard time; and be it further

RESOLVED, That this resolution be immediately forwarded to our House of Delegates at the 2022 AMA Annual Meeting.

Your Reference Committee heard limited but overall supportive testimony in favor of this resolution. The RFS Committee on Legislation and Advocacy was split, raising some concerns including the lack of primary evidence cited in the resolution. The authors addressed this by emphasizing the American Academy of Sleep Medicine Position Statement's strong references. Given the known detrimental health effects of seasonal time changes and current ongoing legislation, your Reference Committee agrees that this is a timely resolution. Therefore, your Reference Committee recommends that Resolution 6 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

- (3) REPORT A – THE SHORTAGE OF BEDSIDE NURSES AND
INTERSECTION WITH CONCERNS IN NURSE
PRACTITIONER TRAINING

RECOMMENDATION A:

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

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

a) RESOLVED, That our AMA study, and encourage relevant advocacy organizations to study, the possible links between the bedside nursing shortage, and expansion of nurse practitioner programs, and the impact of this connection on patient health outcomes; and be it further

b) RESOLVED, That our AMA reaffirm existing policies H-160.947, “Physician Assistants and Nurse Practitioners”, and H-35.996, “Status and Utilization of New or Expanding Health Professionals in Hospitals.”

- ~~2. That your AMA-RFS Governing Council advocate to the AMA Committee on Legislation (COL) and AMA Advocacy Resource Center (ARC) to develop a scope of practice model bill incorporating regulations for the hiring of nurse practitioners to ensure appropriate alignment of clinical training, certification, and competency with the requirements of the position.~~

RECOMMENDATION B:

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

RECOMMENDATIONS

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

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

a) RESOLVED, That our AMA encourage relevant advocacy organizations to study the link between the bedside nursing shortage and expansion of nurse

practitioner programs and the impact of this connection on patient health outcomes; and be it further

- b) RESOLVED, That our AMA reaffirm existing policies H-160.947, "Physician Assistants and Nurse Practitioners", and H-35.996, "Status and Utilization of New or Expanding Health Professionals in Hospitals."

2) That your AMA-RFS Governing Council advocate to the AMA Committee on Legislation (COL) and AMA Advocacy Resource Center (ARC) to develop a scope of practice model bill incorporating regulations for the hiring of nurse practitioners to ensure appropriate alignment of clinical training, certification, and competency with the requirements of the position.

Your Reference Committee heard limited and mixed testimony on this report. One of the authors of the original resolution asked the AMA to conduct and publish a study instead of outside organizations as called for by the report. Considering the AMA is the predominant physician advocacy organization in the country, your Reference Committee believes the AMA is an appropriate organization to take lead and conduct such a study. However, your Reference Committee believes publication may be premature. There currently does not exist any evidence regarding the link between staffing shortages and expansion of nurse practitioner studies and outcomes, hence the need for study.

Your Reference Committee also agrees that it would be appropriate to encourage other organizations to conduct similar studies. The Massachusetts Medical Society spoke in favor of the first resolved clause but in opposition to the second recommendation, due to concerns that creation of a model bill may be overly prescriptive. Your Reference Committee agrees and feels that model legislation may not be the best route of our advocacy efforts. The report outlines a compelling case for increased guidance at the state regulatory level for practice alignment with education and certification. However, this seems outside of the scope of this resolution and our Stop Scope Creep campaign likely has already considered this action. Also, it may be difficult to argue that we as physicians should dictate how NPs are trained considering we don't do this for other specialties such as pharmacy. Therefore, your Reference Committee recommends that Report A be adopted as amended and the remainder of the report be filed.

(4) REPORT B – PRESERVING PHYSICIAN LEADERSHIP IN PATIENT CARE

RECOMMENDATION A:

Report B be amended by deletion to read as follows:

- 1) That our AMA create a national targeted ad campaign to educate the public about the training pathway of physicians compared to non-physician providers.
- 2) That our AMA reaffirm our opposition to physician being referred to as "providers" in healthcare settings ~~and to replace our conflicting policy accordingly with "physicians and non-physician providers" or a similar term.~~

RECOMMENDATION B:

Report B be amended by addition of a Third Recommendation to read as follows:

- 3) That our AMA conduct a review in PolicyFinder and replace any conflicting policy referring to physicians as “providers” with the term “physician”.

RECOMMENDATION C:

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

RECOMMENDATIONS

As scope of practice has been an important topic at the last few meetings and remains a vital concern for our members, the first resolved clause from this resolution was adopted as amended by the RFS Assembly. It has been added to the combined Resolution 217 “Preserving the Practice of Medicine” for consideration at this meeting, A-22.

Based on the report and recommendations prepared by the AMA-RFS Committee on Quality and Patient Safety, your RFS Governing Council recommends the following:

- 1) That our AMA create a national targeted ad campaign to educate the public about the training pathway of physicians compared to non-physician providers.
- 2) That our AMA reaffirm our opposition to physicians being referred to as “providers” in healthcare settings and to replace our conflicting policy accordingly with “physicians and non-physician providers” or a similar term.

Your Reference Committee heard limited but overall supportive testimony in favor of this report. The Massachusetts Medical Society proffered an amendment which was supported by the authors. Your Reference Committee finds that this report addresses the concerns of the original resolution. Therefore, your Reference Committee recommends that Report B be adopted as amended and the remainder of the report be filed.

- (5) REPORT C – COMPARING STUDENT DEBT, EARNINGS, WORK HOURS, AND CAREER SATISFACTION METRICS IN PHYSICIANS V. OTHER HEALTH PROFESSIONALS

RECOMMENDATION A:

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

- 1 1. That our AMA's advocacy efforts are informed by the
2 fact ~~recognize~~ that student debt burden is higher for
3 physicians when compared to physician assistants and
4 nurse practitioners, ~~and thus should be used to better~~
5 ~~inform our advocacy efforts.~~
6
- 7 2. That our AMA work with relevant stakeholders to study:
8
 - 9 a) How total career earnings of physicians
10 compare to those physician assistants and
11 nurse practitioners in order to specifically
12 discern if there is a personal financial
13 disincentive to becoming a physician,
14 considering the relatively high student debt
15 burden and work hours of physicians.
16
 - 17 b) If resident physicians provide a net financial
18 benefit for hospitals and healthcare institutions
19
 - 20 c) Best practices for increasing resident physician
21 compensation so that their services may be
22 more equitably reflected in their earnings
23
 - 24 d) Burnout metrics using a standardized system to
25 compare differences among physicians,
26 physician assistants and nurse practitioners.
27
- 28 3. That our AMA recognize that burnout-centered metrics
29 do not fully characterize work-life balance, ~~is indirectly~~
30 ~~measured through burnout centered metrics, which~~
31 ~~does not adequately measure how it impacts~~
32 particularly for individuals with varying socioeconomic,
33 racial and/or sexual minoritized backgrounds.
34
- 35 4. ~~That this RFS report be forwarded to the AMA HOD for~~
36 ~~the Interim 2022 meeting.~~
37

38 **RECOMMENDATION B:**

39
40 Report C be amended by addition of a new Fourth Resolve
41 to read as follows:

42
43 RESOLVED, That our AMA seek to publish its findings in a
44 peer-reviewed medical journal.
45

46 **RECOMMENDATION C:**

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48 Report C be adopted as amended and the remainder of the
49 report be filed.
50

RECOMMENDATIONS

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

- 1) That our AMA recognize that student debt burden is higher for physicians when compared to physician assistants and nurse practitioners, and thus should be used to better inform our advocacy efforts.
- 2) That our AMA work with relevant stakeholders to study:
 - a) How total career earnings of physicians compare to those physician assistants and nurse practitioners in order to specifically discern if there is a personal financial incentive to becoming a physician
 - 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 practitioners.
- 3) That our AMA recognize that work-life balance is indirectly measured through burnout centered metrics, which does not adequately measure how it impacts individuals with varying socioeconomic, racial and/or sexual minoritized backgrounds.
- 4) That this RFS report be forwarded to the AMA HOD for the Interim 2022 meeting.

Your Reference Committee heard limited but overall supportive testimony in favor of this resolution and appreciates the work done by our AMA-RFS Committees on Business and Economics and Legislation and Advocacy. Your Reference Committee recognizes the benefits of publishing data in journals to be used in advocacy. For this reason, your Reference Committee recommends an additional resolve clause requesting to seek the publication of the findings in a peer-reviewed medical journal. Your Reference Committee also noted multiple clarifying amendments by the authors of the original resolution and believes they help to further streamline the intent of the report. Your Reference Committee does not believe it appropriate to specify the meeting to which these recommendations will be forwarded to the House of Delegates, as this decision is best left at the discretion of your RFS Delegates. Therefore, your Reference Committee recommends that Report C be adopted as amended and the remainder of the report be filed.

- (6) REPORT D – INCREASING MUSCULOSKELETAL
EDUCATION IN PRIMARY CARE SPECIALTIES AND
MEDICAL SCHOOL EDUCATION THROUGH INCLUSION
OF OSTEOPATHIC MANUAL THERAPY EDUCATION

RECOMMENDATION A:

The First Recommendation, First and Second Resolve, of Report D be deleted.

~~a) RESOLVED, That our AMA work with stakeholders such as, ACGME, ACOFP, and AOA to facilitate maintenance of Osteopathic Recognition for those programs that currently hold that status; and be it further~~

~~b) RESOLVED, That our AMA work with stakeholders to expand residency positions in programs with Osteopathic Recognition and facilitate programs wishing to apply for Osteopathic Recognition; and be it further~~

RECOMMENDATION B:

Report D be amended by addition of a new Second Resolve to read as follows:

b) RESOLVED, That our AMA encourage education on the benefits of evidence-based Osteopathic Manual Therapy for musculoskeletal conditions in medical education of allopathic students and in primary care residencies.

RECOMMENDATION C:

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

RECOMMENDATIONS

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

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

a) RESOLVED, That our AMA work with stakeholders such as, ACGME, ACOFP, and AOA to facilitate maintenance of Osteopathic Recognition for those programs that currently hold that status, and be it further;

b) RESOLVED, That our AMA work with stakeholders to expand residency positions in programs with Osteopathic Recognition and facilitate programs wishing to apply for Osteopathic Recognition; and be it further

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

Your Reference Committee heard mixed testimony on this report. Some cited concerns with categorically endorsing osteopathic manual therapy (OMT), a practice that has mixed

evidence with regards to effectiveness depending on the technique and use. Others cited the references in the report to backup claims regarding effectiveness, but also mentioned that it would be tedious to try and prove each and every indication and technique used for manual manipulation. In response, some individuals said it is necessary to ensure the preservation of evidence-based medicine and therapies for patients. Your Reference Committee also heard feedback from the original resolution authors on the intent which was to focus on educating allopathic trainees on these osteopathic techniques. They also offered amendments narrowing the scope in response to concerns, asking the AMA to work with stakeholders to include education on the benefit of OMT to only musculoskeletal conditions. Finally, there was broad support for resolve clause c), which asks for equal treatment of osteopathic students, trainees, and physicians relative to their allopathic counterparts.

Your Reference Committee agrees with the conclusion of Report D that formally incorporating OMT into the curricula of allopathic medical schools and all primary care residency training programs would be an unrealistic ask, given that many of these institutions do not have adequate numbers of faculty who are both trained in and actively practice these techniques. However, your Reference Committee agrees with the original resolution authors that resolve clauses a) and b) do not align with the original intent of the resolution. Furthermore, it is unclear what additional benefit they would bring to the AMA's policy compendium, given the broad, comprehensive policy that exists for expanding access to medical school and graduate medical education.

Your Reference Committee recommends adopting the amendment suggested by the authors with a few slight modifications. Given that OMT is a specific technique which may not be used by physicians in all specialties, your Reference Committee feels it is most appropriate for the AMA to encourage such education without directly providing it itself. Furthermore, it is prudent to specify "evidence-based" to exclude conditions for which OMT may not be well-supported. Finally, to be concise, your Reference Committee combined the amendments offered by the author into one simple resolved clause, and also recommends adoption of resolved clause c). Therefore, your Reference Committee recommends that Report D be adopted as amended and the remainder of the report be filed.

(7) RESOLUTION 2 – ASSESSING THE HUMANITARIAN
IMPACT OF SANCTIONS

RECOMMENDATION A:

The Second Resolve of Resolution 2 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA supports ~~legislative and regulatory~~ efforts to study the humanitarian health impact of economic sanctions imposed by the United States.

RECOMMENDATION B:

Resolution 2 be adopted as amended.

1 RESOLVED, That our AMA recognizes that economic sanctions can negatively impact health
2 and exacerbate humanitarian crises; and be it further
3

4 RESOLVED, That our AMA supports legislative and regulatory efforts to study the
5 humanitarian impact of economic sanctions imposed by the United States.
6

7 Your Reference Committee heard generally supportive testimony on Resolution 2, including
8 from the AMA-RFS Committee on Legislation and Advocacy, the Massachusetts Medical
9 Society, and the American Psychiatric Association. However, multiple individuals were
10 concerned about the broad scope of the resolution, believing that economic impacts and
11 political strategies are outside the purview of the AMA. Others countered that sanctions do
12 directly impact health, which is within the purview of the AMA.
13

14 Your Reference Committee believes that the first resolve clause, which calls for recognition,
15 is not an overly burdensome ask for the AMA and is also well within its purview. For the second
16 resolve, your Reference Committee noted that “legislative and regulatory efforts” are not
17 typically used to “study” issues and that their inclusion into the resolve clauses unnecessarily
18 narrows the intent resolved clause. An amendment is recommended to expand the categories
19 of entities who may conduct such a study while also narrowing the focus slightly to “health”
20 impacts as opposed to “humanitarian.” Therefore, your Reference Committee recommends
21 Resolution 2 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

- (8) RESOLUTION 1 – LEGALIZATION OF FENTANYL TEST STRIPS
RESOLUTION 4 – IN SUPPORT OF DRUG CHECKING SERVICES

RECOMMENDATION A:

Alternate Resolution 1 be adopted in lieu of Resolutions 1 and 4.

ILLICIT DRUG USE HARM REDUCTION STRATEGIES

RESOLVED, That our AMA amend current policy D-95.987, “Prevention of Drug-Related Overdose,” by addition to read as follows:

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

5. Our AMA supports efforts to increase access to fentanyl test strips and other drug checking supplies for purposes of harm reduction.

RECOMMENDATION B:

Alternate Resolution 1 be adopted.

Resolution 1

RESOLVED, That our AMA advocate for the legalization of fentanyl test strips in the United States; and be it further

RESOLVED, That our AMA supports legislative, regulatory, and national advocacy efforts to increase access to fentanyl test strips; and be it further

RESOLVED, That this resolution be forwarded immediately to the House of Delegates at A-22.

Resolution 4

RESOLVED, That our AMA supports legislative, regulatory, and national advocacy efforts to increase access to drug checking services.

1 Your Reference Committee heard mostly supportive testimony on Resolution 1. Testimony
2 noted that the policy goals of the resolution were well-supported by primary evidence. Others
3 shared anecdotes from their own experiences treating opioid overdoses and expressed the
4 need for harm reduction strategies. There was some concern about immediate forwarding
5 given the unusually high volume of resolutions that will be considered by the House of
6 Delegates at its 2022 Annual Meeting. It was also suggested that the resolve clauses may
7 already be covered by current policy D-95.987, Prevention of Drug-Related Overdose,
8 specifically section 4, which was added to the AMA policy compendium recently at Interim
9 2021.

10
11 Your Reference Committee heard limited, mixed testimony on Resolution 4. It was noted that
12 access to drug checking services may provide an opportunity for harm reduction and reduction
13 of morbidity and mortality associated with use of illicit drugs. Others raised concerns that the
14 concept of "drug checking services" is too broad and more research is needed to suggest
15 whether increased access is an advisable policy goal. It was also noted that the aims of the
16 resolution may already be covered in policies D-95.987 and H-95.925.

17
18 Given that these two resolutions relate to harm reduction strategies in the context of illicit drug
19 use, your Reference Committee will consider them as one item. In a recent news article, the
20 AMA recommended decriminalization of fentanyl test strips. Further, current AMA policy D-
21 95.987 calls for "civil and criminal immunity" for "drug contamination testing." Both fentanyl
22 test strips and drug checking services can be considered forms of drug contamination testing.
23 Your Reference Committee also received feedback from AMA staff that "civil and criminal
24 immunity" is, for the purposes of advocacy, a broader and more preferred term than
25 "legalization." Therefore, we believe that the "legalization" asks of Resolutions 1 and 4 are
26 already sufficiently covered in current policy.

27
28 Resolutions 1 and 4, however, also call for increased access to fentanyl test strips and other
29 drug checking services, which your Reference Committee does not believe is explicitly
30 included within current policy. Your Reference Committee agrees with the authors that this is
31 a desirable outcome, and to achieve this, your Reference Committee suggests an amendment
32 to D-95.987 via addition specifying the AMA's support for increased access. Additionally, AMA
33 staff suggested a complementary amendment to D-95.987 to include "possession and
34 distribution" as activities which should have civil and criminal immunity in the context of drug
35 contamination testing for harm reduction purposes.

36
37 Your Reference Committee does not believe that this substitute resolution merits immediate
38 forwarding to the House of Delegates, given the unusually high volume of business under
39 consideration as well as the very recent House action to amend D-95.987 as described above.
40 Therefore, your Reference Committee recommends that Alternate Resolution 1 be adopted
41 in lieu of Resolutions 1 and 4.

42
43 (9) RESOLUTION 3 – COMPREHENSIVE SOLUTIONS FOR
44 MEDICAL SCHOOL GRADUATES WHO ARE UNMATCHED
45 OR DID NOT COMPLETE TRAINING

46
47 **RECOMMENDATION A:**

48
49 **Alternate Resolution 3 be adopted in lieu of Resolution 3.**
50

1 COMPREHENSIVE SOLUTIONS FOR MEDICAL SCHOOL
2 GRADUATES WHO ARE UNMATCHED OR DID NOT
3 COMPLETE TRAINING

4
5 **RESOLVED, That our AMA work with US Centers for**
6 **Medicare and Medicaid Services and other relevant**
7 **stakeholders to create a commission to estimate future**
8 **physician workforce needs and suggest re-allocation of**
9 **available residency funding and available first-year**
10 **positions accordingly; and be it further**

11
12 **RESOLVED, That our AMA-RFS study the possibility of a**
13 **pathway to ACGME certification of training, ABMS board**
14 **certification, and ultimately independent practice in**
15 **primary care for unmatched graduates of US MD and DO**
16 **schools who take roles as "Assistant Physicians" or**
17 **similar positions as established by several states.**

18
19 **RECOMMENDATION B:**

20
21 **Alternate Resolution 3 be adopted.**

22
23 RESOLVED, That our American Medical Association work with the US Center for Medicare
24 and Medicaid Services and sponsor federal legislation as necessary to implement a National
25 Physician Healthcare Workforce Needs Committee, with the responsibility of estimating future
26 physician needs and allocating available residency funding and available first year positions
27 accordingly; and be it further

28
29 RESOLVED, that our American Medical Association work with Physician Associate boards
30 and organizations to establish a special qualification pathway for graduates of US allopathic
31 and osteopathic medical schools to rapidly gain certifications to practice as a Physician
32 Associate, and be it further

33
34 RESOLVED, That our American Medical Association work with the Center for Medicare and
35 Medicaid Services, American Board of Medical Specialties, Accreditation Council for
36 Graduate Medical Education (ACGME), and all interested parties to establish a new specialty
37 of Primary Care Medicine, focused on outpatient primary care only, with residencies open to
38 all those who have completed at least one year of ACGME training, with guaranteed positions
39 available to any physician who was in good standing upon completion of their prior training.

40
41 Your Reference Committee heard mixed testimony on this resolution focused on how to
42 address the underutilization of medical school graduates who do not match into a residency
43 program. There was broad support for the first resolve, which seeks to allocate future
44 residency positions according to future physician workforce needs, but also concerns that it
45 was overly prescriptive. Additional testimony on the first resolve clause raised concerns about
46 the pace at which suggested allocations would be implemented. There was significant
47 opposition to the second and third resolve clauses due to potential challenges associated with
48 implementation, inherent conflicts between the aims of these two resolves, and possible
49 contradictions to scope of practice resolutions already under consideration by the HOD.
50 Specifically, individuals raised concerns that physician training in medical school distinguishes

1 medical school graduates from graduates of Physician Assistant schools, and the two should
2 not be made equivalent. In response, the authors offered a substitute amendment to the
3 second and third resolves, asking that the “AMA study the possibility of a pathway to ACGME
4 certification of training, ABMS board certification, and ultimately independent practice in
5 primary care for unmatched graduates of US MD and DO schools who take roles as ‘Assistant
6 Physicians’ or similar positions as established by several states.” There was also hesitancy
7 at the prospect of bringing this resolution to the House of Delegates without soliciting more
8 input from primary care physicians, including residents and fellows.

9
10 Given this feedback, your Reference Committee suggests an alternate resolution. For the first
11 resolve, the language does not unnecessarily specify the mechanism used to create such a
12 commission. Furthermore, in response to concerns about the pace at which such changes
13 would be implemented, your Reference Committee notes that such a commission or
14 committee would only suggest allocation changes to remedy maldistributions, such as by
15 specialty or geography, but the more politically challenging issue of implementation would be
16 left to another entity and thus outside the scope of this resolution.

17
18 Your Reference Committee recommends adopting the substitute amendment from the author
19 for the second resolve, only changing “AMA” to “AMA-RFS.” Your Reference Committee feels
20 that an internal RFS report would be most appropriate to examine this issue further,
21 particularly to research and consider potential unintended consequences as well as to obtain
22 feedback from primary care physicians in our section as to how this change would impact
23 patient care within their specialties. It would be imprudent to ask the House of Delegates to
24 consider this idea before we, as a Section, gain a more comprehensive understanding of the
25 implications. Therefore, your Reference Committee recommends that Alternate Resolution 3
26 be adopted in lieu of Resolution 3.

27
28 (10) RESOLUTION 5 – THE CRIMINALIZATION OF MEDICAL
29 ERRORS

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31 **RECOMMENDATION A:**

32
33 **Alternate Resolution 5 be adopted in lieu of Resolution 5.**

34
35 THE CRIMINALIZATION OF HEALTH CARE DECISION
36 MAKING AND PRACTICE

37
38 **RESOLVED, That policy H-160.946, “The Criminalization of
39 Health Care Decision Making” be amended by addition and
40 deletion addition with a change in title to read as follows:**

41
42 **The Criminalization of Health Care Decision Making and**
43 **Practice H-160.946**

44
45 **That our The AMA: (1) opposes the attempted**
46 **criminalization of health care decision-making, practice,**
47 **malpractice, and medical errors, including medication**
48 **errors related to electronic medical record or other system**
49 **errors, especially as represented by the current trend**

1 ~~toward criminalization of malpractice~~; it interferes with
2 appropriate decision making and is a disservice to the
3 American public; and (2) actively update and promote will
4 ~~develop~~ model state legislation properly defining criminal
5 conduct and prohibiting the criminalization of health care
6 decision-making and practice, including cases involving
7 allegations of medical malpractice and medical errors; and
8 (3) implement an appropriate action plan for all
9 components of the Federation to educate opinion leaders,
10 elected officials and the media regarding the detrimental
11 effects on health care resulting from the criminalization of
12 health care decision-making, practice, malpractice, and
13 medical errors.

14
15 RESOLVED, that our AMA study the increasing
16 criminalization of health care decision-making, practice,
17 malpractice, and medical errors with report back on our
18 advocacy to oppose this trend.

19
20 RESOLVED, That our AMA study the ramifications of trying
21 all health care decision-making, practice, malpractice, and
22 medical error cases in health courts instead of criminal
23 courts.

24
25 RESOLVED, That our AMA reaffirm policies H-120.921, H-
26 160.954, H-375.984, H-375.997, and H-435.950; and be it
27 further

28
29 RESOLVED, That this resolution be immediately forwarded
30 to the AMA House of Delegates at A-22.

31
32 **RECOMMENDATION B:**

33
34 **Alternate Resolution 5 be adopted.**

35
36 RESOLVED, That Policy H-160.946, "The Criminalization of Health Care Decision Making"
37 be amended by addition and deletion addition to read as follows:

38
39 That our The AMA: (1) opposes the attempted criminalization of health care decision-
40 making, malpractice, and medical errors ~~especially as represented by the current trend~~
41 ~~toward criminalization of malpractice~~; it interferes with appropriate decision making
42 and is a disservice to the American public; and (2) actively update, promote, and report
43 back biennially on will develop model state legislation properly defining criminal
44 conduct and prohibiting the criminalization of health care decision-making, including
45 cases involving allegations of medical malpractice and unintentional medical errors; and
46 (3) implement an appropriate action plan for all components of the Federation to
47 educate opinion leaders, elected officials and the media regarding the detrimental
48 effects on health care resulting from the criminalization of health care decision-making,
49 malpractice, and medical errors. (Modify Current HOD Policy); and be it further
50

1 RESOLVED, That Policy H-120.968, "Medication (Drug) Errors in Hospitals" be amended by
2 addition and deletion addition to read as follows:

3 (3) Our AMA opposes the criminalization of unintentional medication errors related to
4 electronic medical record or other system errors. (Modify Current HOD Policy); and be
5 it further
6

7 RESOLVED, That Policy H-435.951, "Health Court Principles" be amended by addition and
8 deletion addition to read as follows:

9 AMA PRINCIPLES FOR HEALTH COURTS

- 10
11 - These principles are intended to serve as legislative guidelines for state medical
12 associations and can be amended on an as needed basis.
13 - Cases addressing medical decision-making, malpractice, and unintentional medical
14 error should be the subject of health courts and not criminal courts.
15 - Health courts should be structured to create a fair and expeditious system for the
16 resolution of medical liability claims - with a goal of resolving all claims within one year
17 from the filing date.
18 - Health court judges should have specialized training in the delivery of medical care
19 that qualifies them for serving on a health court.
20 - Negligence should be the minimum threshold for compensation to award damages.
21 - Health court judgments should not limit the recovery of economic damages, but non-
22 economic damages should be based on a schedule.
23 - Qualified experts should be utilized to assist a health court in reaching a judgment.
24 - Health court pilot projects should have a sunset mechanism in place to ensure that
25 participating physicians, hospitals, and insurers do not experience a drastic financial
26 impact based on the new judicial format. (Modify Current HOD Policy); and be it further
27

28 RESOLVED, That Policy D-160.999, "Opposition to Criminalizing Health Care Decisions" be
29 rescinded (Rescind HOD Policy); and be it further
30

31 RESOLVED, That our AMA reaffirm policies H-120.921, H-160.954, H-375.984, H-375.997,
32 and H-435.950 (Reaffirm HOD Policy); and be it further
33

34 RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates
35 at A-22.
36

37 Your Reference Committee heard testimony almost exclusively in support of Resolution 5,
38 particularly the first resolve. However, testimony regarding other resolve clauses was very
39 limited or absent. Comments were made on the timeliness of this resolution, given the recent
40 case of an unintentional medical error in Tennessee in which a nurse was found guilty of
41 criminally negligent conduct. An amendment was offered to add "practice" to categories of
42 health care activities for which the AMA should oppose criminalization, given that
43 routine/evidence-based medical practices such as abortions, home safety checks, and
44 vaccine delivery have been criminalized, or there have been discussion regarding
45 criminalizing these health care activities. There was one comment of concern that reporting
46 back on model legislation every two years would be overly prescriptive. Additionally, your
47 Reference Committee received feedback from AMA staff that this resolution would not
48 meaningfully change the AMA's advocacy in the realm of criminalization of health care, as
49 "health care decision making," can be considered a broad, all-encompassing term. Staff

1 feedback opposed the removal of the word “attempted” because the original intent was for the
2 AMA to also oppose criminal indictments, grand jury inquiries, and arrests.

3
4 Your Reference Committee believes that while health care decision-making has been applied
5 by our AMA as a broad term, there is value in adding “practice, malpractice, and medical
6 errors” to H-160.946 to leave no room for ambiguity in our policy. Your Reference Committee
7 notes that model legislation created by the AMA in 2007 is broader than the text of H-160.946,
8 stating “Any physician licensed to provide healthcare services in the state who, in the absence
9 of criminal intent, renders or fails to render healthcare services, shall not be subject to criminal
10 liability resulting from any act or omission related to such rendering of or failure to render
11 health care services.” However, given that this is a timely issue which may be increasing in
12 importance, we believe that an update to model legislation, accounting for developments
13 which may have occurred in the past 15 years, is appropriate to ensure that our legislative
14 efforts remain timely and nimble. Your Reference Committee recommends not including the
15 word “unintentional,” as originally included by the authors, as an “error” is, by definition,
16 unintentional.

17
18 Moreover, the authors requested a report back every two years regarding the AMA’s model
19 legislation on this topic. Your Reference Committee believes that an ongoing, biennial report
20 back to the House of Delegates would be overly prescriptive. However, we believe that a
21 broader report back on this topic, including but not limited to our updated model legislation, is
22 warranted. Finally, your Reference Committee believes that there is, in practice, little
23 meaningful distinction, if any, between “attempted criminalization” and “criminalization” as
24 these terms relate to this topic. However, given staff feedback that “attempted criminalization”
25 may be slightly broader, the word “attempted” was not stricken from H-160.946.

26
27 Regarding the second resolve, your Reference Committee heard no testimony, but believes
28 that policy H-160.946, as amended by this resolution, is sufficient to oppose criminalization of
29 medical errors related to the EHR and other systems issues. Your Reference Committee feels
30 that H-160.946, which deals with the topic of criminalization, is a more appropriate location for
31 this policy within our compendium as opposed to H-120.968, which describes a set of best
32 practices for physicians related to preventing medication errors. Regarding the third resolve,
33 your Reference Committee heard limited testimony, but believes that there may be unintended
34 consequences and that a greater understanding of this issue, as it relates to health courts, is
35 needed before making a recommendation to try all such cases in health courts. Therefore,
36 your Reference Committee recommends a study on this topic.

37
38 Regarding the fourth resolve, your Reference Committee heard very limited testimony. There
39 was one comment in opposition, questioning the need to rescind a separate component of
40 policy opposing the criminalization of health care decision making. Your Reference
41 Committee believes rescinding this policy would be premature until model legislation is
42 updated, and furthermore, supports continued education of physicians regarding the
43 continuing threat posed by criminalization of healthcare decision-making. If appropriate, this
44 policy may eventually be rescinded via sunset review. Your Reference Committee heard no
45 testimony regarding resolve clauses 5 and 6. However, your Reference Committee agrees
46 with reaffirmation and feels that this is a timely issue that would be appropriate for the House
47 of Delegates to discuss at this meeting. Therefore, your Reference Committee recommends
48 that Alternate Resolution 5 be adopted in lieu of Resolution 5.

RECOMMENDED FOR REFERRAL

- (11) RESOLUTION 7 – ANALYSIS OF ANTITRUST LEGISLATION
REGARDING THE AAMC, ACGME, NRMP, AND OTHER
RELEVANT ASSOCIATIONS OR ORGANIZATIONS

RECOMMENDATION:

Resolution 7 be referred.

RESOLVED, That our AMA advocate for significant modification or the repeal of Section 207 of the Pension Funding Equity Act of 2004 such that evidence of anti-competitive actions against the NRMP be admissible in federal court; and be it further

RESOLVED, That our AMA work with relevant stakeholders to study alternative strategies for resident matching that ensure comparable efficiency and adequate market appreciation for medical residents.

Your Reference Committee heard limited, mixed testimony on this resolution. There was support of the intent to improve market appreciation for residents, but concerns about the downstream and unintended effects of adopting this resolution. Opposition also argued that the dynamics of the residency matching issue have changed since this law was passed in 2004, such that repeal of Section 207 may not work in the favor of medical trainees. An amendment was offered by the Massachusetts Medical Society to study the impact that repeal of Section 207 would have on trainees.

Your Reference Committee believes that the Resident and Fellow Section would be best served by developing a full internal report on this subject, potentially with recommendations for broad policy, which could then be sent as a resolution to the House of Delegates at a future meeting. Your Reference Committee agrees that further research into alternative methods of residency matching or hiring which provides equivalent efficiency while improving the bargaining power of the residents is warranted before advocacy on this issue begins. Therefore, your Reference Committee recommends that Resolution 7 be referred for study.

Benjamin Meyer, MD, Chair

Gunjan Malhotra, MD, Vice Chair

Christopher Clifford, MD

Sophia Yang, MD

Anna Yap, MD