

Resident and Fellow Section

2022-2023 Digest of Actions

American Medical Association Resident and Fellow Section Digest of Actions

The Digest of Actions is a compilation of resolutions and reports adopted by the American Medical Association-Resident and Fellow Section (AMA-RFS) Assembly since its inception in 1978. Actions reflected in the Digest are indexed and classified under their most closely related topic area, however some actions may span several categories. The letter "R" added to the end of each number indicates that it was an action taken in the RFS. Furthermore, relevant AMA House of Delegates policies are identified in the Digest where applicable; however, the listing is not exhaustive.

Resolutions and Reports from 1978 - 2007 have undergone a "sunset" process. Those actions that were reaffirmed by the Assembly are so noted. The other actions, which were rescinded, or "sunset," are no longer included.

If you would like help with a search of AMA-RFS actions or AMA policy, please email rfs@ama-assn.org. We welcome your comments and suggestions.

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10.000R ACCIDENT PREVENTION

10.001R Accident Prevention: Concussions: That our AMA-RFS support state-based initiatives to require prevention for all contact sports in pediatric and young adult populations by: (1) encouraging the use of protective equipment in sports, (2) encouraging sports physicals to include a basic neurocognitive screening by qualified healthcare professionals for pediatric and young adults populations playing contact sports (3) urging policy on return to play protocol for athletes to achieve optimal recovery and reduce or avoid long term health outcomes (4) advocating for education on increasing concussion awareness among the public, coaches and the medical community. (Resolution 17, A-16)

10.002R Amending Child Restraints Laws: That our AMA-RFS support federal legislation that increases law enforcement standards for child safety seat use in the U.S. and support state and federal legislation that updates child car seat violations from a secondary to a primary law. (Resolution 4, A-07)

10.003R Ethylene Glycol Poisoning Prevention: That our AMA-RFS support the AMA asking the Consumer Product Safety Commission to study and propose appropriate regulation including, but not limited to, the possible addition of bittering agents, to prevent ethylene glycol poisoning. (Substitute Resolution 3, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

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

10.005R Winter Sports Safety Act: That our AMA-RFS support mandating the use of protective headgear by children and adolescents during their participation in winter sports including, but not limited to, skiing. (Substitute Resolution 18, I-95) [See also: AMA Policy H-470.974] (Reaffirmed Report D, I-16)

10.006R Promoting Protective Guards and Helmet Use in In-Line Skating: That our AMA-RFS support working with other organizations concerned with health and safety to ensure widespread distribution of information and educational materials about in-line skating including the use of protective wrist, elbow, and knee guards and helmets. (Resolution 29, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

20.000R ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

20.001R Global HIV/AIDS Prevention: That our AMA-RFS: (1) support continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives, or grantee pledges of opposition to prostitution, and (2), support comprehensive family-life education to foreign aid programs, promoting abstinence as the best method to

prevent sexually-transmitted disease transmission while also discussing the role of condoms in disease prevention. (Late Resolution 5, A-08)

- 20.002R** Support of a National HIV/AIDS Strategy: That our AMA-RFS support the concept of a national HIV/AIDS strategy and that our AMA-RFS support the following guiding principles: (a) Improve prevention, care, and treatment outcomes through reliance on evidence-based programming; (b) Set ambitious and credible prevention, care, and treatment targets and require annual reporting on progress toward goals; (c) Identify clear priorities for action across federal agencies and assign responsibilities, timelines, and follow-through; (d) Include, as a primary focus, the prevention and treatment needs of African Americans and other communities of color, women of color, men who have sex with men (MSM) of all races and ethnicities, and other groups at elevated risk for HIV; (e) Address social, economic, and structural factors that increase vulnerability to HIV infection; (f) Promote a strengthened and more highly coordinated HIV prevention and treatment research effort; (g) Involve many sectors in developing the Strategy, including government, business, community, civil rights organizations, faith-based groups, researchers, and people living with HIV/AIDS; and (h) With the White House Office of National AIDS Policy, the Department of Health and Human Services Office of HIV/AIDS Policy, and other relevant bodies to develop, enact, and maintain a national HIV/AIDS strategy. (Resolution 4, A-09)
- 20.003R** Review of AMA Policy on HIV-Infected Physicians: That our AMA-RFS strongly support proposed changes in the Council on Ethical and Judicial Affairs (CEJA) Opinion 4-A-99, *Physicians and Infectious Diseases and CEJA* and Opinion 5-A-99, *HIV-Infected Patients and Physicians*, which change the terminology regarding the level of risk of physician-to-patient transmission of bloodborne infections appropriate for restricting a physician's medical practice from "identified risk" to "significant risk". (Substitute Resolution 3, A-99) (Reaffirmed Report C, I-09)
- 20.004R** Bloodborne Pathogen Chemoprophylaxis for Medical Students and Residents: That (1) our AMA encourage OSHA to make the prophylaxis standard for HIV equivalent to that of HBV, (2) our AMA encourage the FDA to label saquinavir mesylate, ritonavir, nelfinavir, and indinavir sulfate which are currently labeled for HIV treatment, for HIV prophylaxis, and (3) our AMA-RFS ask the Liaison Committee for Medical Education to survey medical schools on their policies regarding chemoprophylactic treatment of students in the event of a possible exposure to a blood borne pathogen and report back to the RFS and the Medical Student Section. (Report L, A-97) (Reaffirmed Report D, I-16)
- 20.005R** Prevention of Prenatal Transmission of HIV: That our AMA-RFS support federal legislation requiring HIV testing of all pregnant women at the earliest prenatal visit, except when there is a specific signed refusal, in order to allow women the opportunity to improve their own health and that of their child. (Resolution 3, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 20.006R** Discrimination Against Persons with HIV/AIDS Seeking Rehabilitative, Residential, and Nursing Care Placements: That our AMA-RFS oppose discrimination against

persons with HIV/AIDS seeking rehabilitative, residential and nursing care placements for the reason of HIV/AIDS positive status. (Resolution 7, A-15)

30.000R ALCOHOL AND ALCOHOLISM

30.001R Alcohol and Youth: That our AMA-RFS support: (1) state medical societies working with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol and (2) working with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents. (Substitute Resolution 9, A-01) [HOD Resolution 415, I-01]

30.002R Advertising of Alcoholic Beverages: That our AMA-RFS oppose televised advertising of alcoholic beverages. (Substitute Resolution 38, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

40.000R ALLIED HEALTH PROFESSIONS

40.001R Midwifery Scope of Practice and Licensure: That our AMA-RFS support: (1) the development of model legislation regarding appropriate physician and regulatory oversight of midwifery practice, under the jurisdiction of either state nursing or medical boards; (2) monitoring state legislation activities regarding the licensure and scope of practice of midwives; and (3) and that our AMA work with state medical societies and interested specialty societies to advocate in the interest of safeguarding maternal and neonatal health regarding the licensure and the scope of practice of midwives. (Resolution 5, A-08)

40.002R Mid-Level Practitioner Tracking System: That our AMA-RFS support the tracking of mid-level practitioners for the purpose of identifying their role in underserved rural communities. (Resolution, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

40.003R Amend AMA Policy H-215.981 Corporate Practice of Medicine: That our AMA-RFS support the AMA in amending policy H-215.981 Corporate Practice of Medicine, to read: 4. Our AMA acknowledges that the corporate practice of medicine has led to erosion of the physician-patient relationship, erosion of physician-driven care and created a conflict of interest between profit and training the next generation of physicians. (Resolution 6, I-21)

40.004R The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training: That our AMA-RFS support that the AMA study, and encourage relevant advocacy organizations to study, the possible links between the bedside nursing shortage, expansion of nurse practitioner programs, and the impact of this connection on patient health outcomes; and (2) That our AMA-RFS support our AMA in reaffirming 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.” (Report A, A-22)

50.000R CHILDREN AND YOUTH

- 50.001R** Pediatric Suspected Intentional Trauma: That our AMA-RFS: (1) support comprehensive reporting and investigation of all cases of reasonably suspected child abuse and neglect using an inclusive and interdisciplinary method in accordance with state and federal laws; and (2) support the creation of a national standardized pediatric intentional trauma curriculum for medical students and residents. (Resolution 3, A-07)
- 50.002R** Home Sedation for Children Undergoing Outpatient Procedures: That our AMA-RFS oppose the administration of pre-procedural sedation to children outside of a monitored healthcare setting. (Report F, A-06) [See also: Resolutions 805, I-06] (Reaffirmed Report D, I-16)
- 50.003R** Harmful Practices in Child Athletics: That our AMA-RFS: (1) support working with all interested organizations to identify harmful practices in the sports training of children and adolescents; and (2) support the establishment of appropriate health standards for sports training of children and adolescents. (Substitute Resolution 28, I-95) [See also: AMA Policy H-60.966] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 50.004R** Opposition to Proposed Budget Cuts in WIC and Head Start: That our AMA-RFS oppose any reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education. (Late Resolution 1, I-94) [See also: AMA Policy H-245.979] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 50.005R** Protection of Pre-school Children from Passive Smoking: That our AMA-RFS oppose the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or child-care purposes. (Substitute Resolution 17, A-94) [See also: AMA Policy H-60.954] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 50.006R** Childcare at AMA Meetings: That our AMA-RFS: (1) support the AMA offering organized childcare services at all AMA national meetings; and (2) Hospitality Committee and other relevant stakeholders publicize family friendly activity information within each meetings' respective host cities. (Report F, I-15)
- 50.007R** Separation of Children from their Parents at Border: That our AMA-RFS: (1) oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being; and (2) support the federal government withdrawing its policy of requiring separation of migrating children from their caregivers, and instead, giving priority to supporting families and protecting the health and well-being of the children within those families. (Emergency Resolution, A-18)
- 50.008R** Allowing Mature Minors to Consent for Vaccinations: That our AMA-RFS support national and state efforts for allowing emancipated mature minors to give their own informed consent for vaccinations. (Resolution 6, A-19)

60.000R DISABLED

60.001R Guidelines for Certifying Need for Handicapped Parking: That our AMA-RFS support the development of guidelines to assist physicians in determining a patient’s need for handicapped parking privileges. [HOD Substitute Resolution 30, A-96] (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

60.002R A Study to Evaluate Barriers to Medical Education for Trainees with Disabilities: That our AMA-RFS support working with relevant stakeholders to study available data on medical trainees with disabilities and consider revision of technical standards for medical education programs. (Resolution 11, A-18)

70.000R DRUG ABUSE

70.001R Needle Exchange Programs: That our AMA-RFS support governmental funding of needle exchange programs that provide the opportunity to participate in a drug rehabilitation program. (Substitute Resolution 4, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

70.002R Harm Reduction Strategies for Patients at Risk of Opioid Overdose: That our AMA-RFS: (1) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (2) support the study appropriate treatments and risk mitigation methods for patients at risk for opioid overdose. (Resolution 4, A-12) (Reaffirmed Report E, A-22)

80.000R DRUGS

80.001R Use of a Single National Prescription Drug Monitoring Program (PDMP): That our AMA-RFS: (1) support the creation of one national prescription drug monitoring program (PDMP) database of controlled substances for physicians to detect and monitor prescription drug abuse; and (2) oppose requirements that physicians must consult such programs before prescribing medications. (Resolution 11, A-14)

80.002R Prescription Drug Shortages, A National Emergency: That our AMA-RFS acknowledge the critical issue of medicine shortages in the United States and support legislative efforts to address these issues. (Resolution 2, I-11)

80.003R Reviewing the Effectiveness of Current Drug Policies: That our AMA-RFS (1) support the review of the effectiveness of current drug policies pertaining to illegal drug use; (2) support the review of the current availability of and access to evidence-based treatments for drug abuse and dependence; (3) support the review of the effectiveness of current medical training for primary care physicians in evaluating and treating drug abuse; and (4) monitor the work on this issue by both national and international organizations, including, but not limited to the National Institute of Drug Abuse, United Nations, WHO, UNODC, and UNAIDS. (Resolution 2, I-10)

80.004R Abuse of Free-Market Pharmaceuticals: That our AMA-RFS support: (1) pharmaceutical pricing that is fair and reasonable to consumers, and (2) that the

Centers for Medicare and Medicaid Services be granted the right to negotiate drug prices with pharmaceutical companies. (Late Resolution 3, I-15).

- 80.005R** Regulation of Herbal Preparations: That our AMA-RFS support modification of the Dietary Supplement Health and Education Act (DSHEA) to require that dietary supplements, in order to be marketed: (1) undergo Food and Drug Administration (FDA) pre-approval for evidence of safety; (2) meet criteria established by the United States Pharmacopoeia (USP) for dosage, quality, purity, packaging, and labeling; (3) meet FDA post-marketing requirements to report adverse side effects, including drug interactions and that the AMA encourage efficacy studies on dietary supplements. (Substitute Resolution 11, I-98) (Reaffirmed Report D, I-16)
- 80.006R** Ban on Nonprescription Acetaminophen with Ethanol: That our AMA-RFS support the FDA requiring appropriate warning labels on nonprescription products containing both acetaminophen and ethanol. (Substitute Resolution 35, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 80.007R** Limiting Use of the DEA Number: That our AMA-RFS support the AMA working with the DEA to develop regulations prohibiting the use of the DEA number for purposes other than those related to controlled substances. (Substitute Resolution 34, A-94) [AMA Res. 209, I-94 was adopted as a reaffirmation. See also: AMA Policy H-100.972] (Reaffirmed Report D, I-16)
- 80.008R** Drug Costs and Shortages: That our AMA-RFS support legislative and regulatory mechanisms to ensure more affordable generic biosimilar access without placing undue burdens on drug innovation; and support the repeal of the 1987 Safe Harbor exemption to the Anti-Kickback Statute for Group Purchasing Organizations (GPO) and Pharmacy Benefit Managers (PBM). (Report J, A-19)
- 80.009R** Medicare Coverage of Dental, Vision, and Hearing Services: That our AMA-RFS support the AMA in supporting new Medicare funding that is independent of the physician fee schedule for coverage of: (1) preventive dental care, including dental cleanings and x-rays, and restorative services, including fillings, extractions, and dentures; and (2) routine eye examinations and visual aids, including eyeglasses; and amending AMA Policy H-185.929 Hearing Aid Coverage to read: 4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team, aural rehabilitative services, and hearing aids as part of Medicare's Benefit. (Resolution 8, I-21)
- 80.010R** Illicit Drug Use Harm Reduction Strategies: That our AMA-RFS support the AMA in amending 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. (Alternate Resolution 1, A-22)

90.000R EMERGENCY MEDICAL SERVICES

90.001R Emergency Preparedness: That our AMA-RFS: 1) commend the physicians and other volunteers who demonstrated the true spirit of medicine during the September 11, 2001 terrorist attacks, (2) support the AMA's development and maintenance of a physicians volunteer database, and (3) support the AMA's effort to educate physicians on natural and man-made disaster related topics. (Substitute Resolution 1, I-01)

90.002R Improvement in US Airlines Aircraft Emergency Kits: That our AMA-RFS: (1) support the FAA reporting on medical emergencies that occur in US air carrier domestic and international flights; and (2) support the review of the content of US air carriers airline emergency kits and recommendation of appropriate upgrades of these kits. (Substitute Resolution 17, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

90.003R Emergency Medical Skills Training in Medical Education: That our AMA-RFS support the proposition that a formal emergency medicine experience including didactic and clinical training in basic skills should be a part of undergraduate medical education. (Resolution 8, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

90.004R The Intracranial Hemorrhage Anticoagulation Reversal (ICHAR) Initiative: That our AMA-RFS support initiatives to improve and reduce the barriers to the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening clinical indications. (Resolution 5, I-17)

100.000R ETHICS

100.001R Code Status Requirements for Nursing Home Residents: That our AMA-RFS: (1) oppose any requirement that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care; 2) oppose any legislative or regulatory attempts that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care. (Substitute Resolution 8, I-97) (Reaffirmed Report C, I-07) [Also see AMA Policy H-140.945]

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)

100.003R Filming Patients for News or Entertainment: That our AMA-RFS assert that efforts to disguise a patient (such as blurring the face, changing the voice, or any other technology) do not obviate the need to obtain consent as outlined in AMA Policy E-

5.045 for publication of any material related to the treatment of a patient.
(Resolution 1, A-15)

- 100.004R** Ethical Physician Conduct in the Media: That our AMA-RFS support: (1) an AMA report on the professional ethical obligations for physicians in the media, including guidelines for the endorsement and dissemination of general medical information and advice via television, radio, internet, print media, or other forms of mass audio or video communication; (2) an AMA study of disciplinary pathways for physicians who violate ethical responsibilities through their position on a media platform; and (3) the release of a statement affirming the professional obligation of physicians in the media to provide quality medical advice supported by evidence-based principles and transparent to any conflicts of interest, while denouncing the dissemination of dubious or inappropriate medical information through the public media including television, radio, internet, and print media. (Resolution 21, A-15)
- 100.005R** Medical Aid in Dying: That our AMA-RFS support: (1) the AMA ending its practice of using the term “physician-assisted suicide” and instead replace it with “medical aid in dying”; (2) 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. (Report D, A-19)
- 100.006R** Adopting a Neutral Stance on Medical Aid and Dying: 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. (Resolution 8, A-23)
- 110.000R** **FIREARMS: SAFETY AND REGULATION**
- 110.001R** Firearm Background Checks: That our AMA-RFS support: (1) waiting periods and background checks for all firearm purchasers; (2) state and federal legislation enforcing waiting periods for all transactions and background checks for all purchasers during firearm transactions; and (3) legislation prohibiting the manufacture, sale, or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. (Resolution 9, A-16) (Reaffirmed in lieu of Resolution 7, A-17)
- 110.002R** Restoring CDC Funding to Research Gun Violence: That our AMA-RFS support the federal funding of the Centers for Disease Control and Prevention (CDC) for research into guns and violence. (Substitute Resolution 15, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 110.003R** AMA Campaign to Reduce Firearm Deaths: That our AMA-RFS support the AMA's extensive efforts to counter the increasing number of firearm-related deaths in the United States. (Substitute Resolution 25, I-92) (Reaffirmed Item 1, Report C, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)
- 110.004R** Improving Medical Clearance Policies for Cognitive Impairment: That our AMA-RFS support advocacy for physician-led committees (i.e., medical advisory boards)

in each state to provide recommendations to the state regarding further driving and/or gun use by individuals who are cognitively impaired and possibly a danger to themselves or others, as stated in federal law 18 U.S.C. § 922(g)(4). (Resolution 1, A-19)

110.005R Stand Your Ground Laws: That our AMA-RFS support our AMA in studying the public health implications of “Stand Your Ground” laws and castle doctrine. (Late Resolution 1, A-23)

120.000R **FOODS AND NUTRITION**

120.001R U.S. Farm Subsidies: That our AMA-RFS support reform and updates to the US Farm Bill including redirecting subsidies in the US Farm Bill that perpetuate calorie-dense, nutrition-poor products toward programs aimed at combating obesity. (Resolution 1, I-11)

120.002R Healthy Food Options for Shift Workers: That our AMA-RFS support encouraging companies who have shift workers to explore making healthier food options available to workers during the evening and nighttime hours. (Report H, A-09)

120.003R Support of Calorie Labeling in Restaurants: That our AMA-RFS support working with state medical associations, state restaurant associations, state departments of health, and other interested parties to promote the display of nutritional information on restaurant menus and menu boards for all food and beverage items. (Resolution 4, I-08)

120.004R Truth in Nutrition Labeling: That our AMA-RFS support: (1) FDA policy requiring manufacturers to include levels of trans fatty acids on the “nutrition facts” portion of food labels; and (2) the development of guidelines for labeling foods as “low fat” and “low cholesterol” which include levels of trans fatty acids. (Substitute Resolution 9, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

120.005R Nutritional Guidelines for Restaurants: That our AMA-RFS supports: (1) restaurants serving foods with reduced saturated fat content, (2) consideration of dietary needs when planning menus, and (3) restaurants providing nutritional information on menus and signage. (Report H, I-94) [See also: AMA Policy H-150.979] (Reaffirmed Report D, I-16)

120.006R Banning the Artificial Use of Trans Fats in the United States: That our AMA-RFS support a total ban on using artificial trans fats in food products. (Resolution 14, A-15)

120.007R Promoting Nutrition Education Among Healthcare Providers: That our AMARFS support the AMA in reaffirming H-465.988 Educational Strategies for Meeting Rural Health Physician Shortage. (Resolution 4, I-18)

130.000R **HEALTH CARE DELIVERY**

- 130.001R** Opting Out of Health Information Exchanges: That our AMA include in its current ongoing study of health information exchanges, concern for potential risks to patient privacy and safeguards against compromise of patient information. (Resolution 3, I-11)
- 130.002R** Marriage Equality to Reduce Health Care Disparities: That our AMA-RFS support ending the exclusion of same-sex couples from civil marriage in order to reduce health care disparities affecting those gay and lesbian individuals and couples, their families and their children. (Resolution 5, A-10)
- 130.003R** Medical Confidentiality of Sexual Orientation in the Military: That our AMA-RFS oppose the use of sexual orientation, same sex marriage or domestic partnerships obtained in patient-physician, or other patient-health care provider communications from being the basis for dismissal from the US Military in order to not impede the patient-physician relationship and to improve the provision of good medical care to all of our service personnel. (Resolution 1, I-09)
- 130.004R** Access to Equivalent Benefits for Children and Other Dependents of Military Personnel with Same Sex Marriages: That our AMA-RFS support US military personnel in legal same sex marriages having the ability to acknowledge these relationships and receiving equal death benefits and other benefits (including health care coverage) to the dependent children and spouses of legal same sex marriages as provided to married US military personnel. (Resolution 2, I-09)
- 130.005R** Removing Barriers to Care for Transgender Patients: That our AMA (1) support public and private health insurance coverage for treatment of gender identity and (2) oppose categorical exclusions of coverage for treatment of gender identity disorder when prescribed by a physician. (Resolution 1, I-07)
- 130.006R** Cost-Effectiveness of Medicaid Eligibility Criteria for the Chronically Ill: That our AMA examine the appropriateness and cost-effectiveness of “the spend down option” to meet Medicaid eligibility criteria in the broader context of Medicaid reform with a report back at I-02. (Substitute Resolution 6, A-01) [HOD Resolution 102, I-01]
- 130.007R** Medic Alert Card: That our AMA-RFS support the study of a portable mechanism for patient information storage which may include a voluntary card-based system, ensuring that patient confidentiality is protected, and uniform standards are maintained. (Substitute Resolution 26, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 130.008R** Early and Periodic Screening, Diagnosis, and Treatment: That our AMA-RFS support guaranteed Medicaid coverage of basic preventative services and treatment of diseases found on screening for children and adolescents including those covered by the Early and Periodic Screening, Diagnosis, and Treatment component.
- 130.009R** Impact of Medicaid Reform on Children: That our AMA-RFS support continued federal and state funding for Medicaid which at minimum provide adequate benefits based on national standards for all people meeting basic national standards of

eligibility. (Substitute Resolution 11, A-96) (Reaffirmed Report C, I-06)
(Reaffirmed Report D, I-16)

- 130.010R** Rural Healthcare Initiative: That our AMA-RFS support financial incentives, such as federal tax incentives, to both rural health care providers and rural health care institutions serving patient populations that fall outside a 60-mile radius of urban areas with a population of 50,000 or greater. (Substitute Resolution 16, A-95) [See also: AMA Policy H-465.994, H-465.997] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 130.011R** Hospital Stay for Healthy Term Newborns: That our AMA-RFS: (1) support the American Academy of Pediatrics and American College of Obstetricians and Gynecologists' guidelines concerning post-delivery care for mothers and their newborn infants and encourage state and federal legislation supporting these policies; and (2) support legislation mandating reimbursement for appropriate post-delivery care. (Substitute Resolution 6, I-95) [See also: AMA Policy 320.954] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 130.012R** National Health Issues: That our AMA-RFS Governing Council continue to review national health issues and ways in which the AMA-RFS could influence these issues, and report to the AMA-RFS Assembly as appropriate. (Resolution 19, A-78) (Reaffirmed Report C, I-88) (Reaffirmed Report C, I-98) (Reaffirmed Report D, I-16)
- 130.013R** Physician Stewardship of Health Resources: That our AMA-RFS support: (1) the position that physicians have an ethical duty to be responsible stewards of health system resources and should seek to practice cost-conscious medicine when feasible while maintaining the primacy of the patient's best interest; and (2) efforts by academic institutions and accrediting bodies to improve residents' and fellows' education regarding cost-conscious medicine. (Resolution 7, A-12) (Reaffirmed Report E, A-22)
- 130.014R** Comprehensive Breast Cancer Treatment: That our AMA-RFS: (1) believes that reconstruction of the breast for rehabilitation of the post treatment patient with in situ or invasive breast neoplasm should be considered reconstructive surgery rather than aesthetic surgery; (2) supports education for physicians and breast cancer patients on breast reconstruction and its availability; (3) recommends that third party payers provide coverage and reimbursement for medically necessary breast cancer treatments including but not limited to prophylactic contralateral mastectomy and/or oophorectomy; (4) recognizes the validity of contralateral breast procedures needed for the achievement of symmetry in size and shape, and urges recognition of these ancillary procedures by Medicare and all other third parties for reimbursement when documentation of medical necessity is provided; (5) acknowledge that access to breast reconstruction is a pivotal part of the breast cancer care pathway; and (6) advocate that reconstructive techniques for partial mastectomy be covered to the same degree as reconstruction following complete mastectomy. (Resolution 2, A-18) [See also AMA Policy H55.973]

- 130.015R** Mandating Critical Congenital Heart Defect Screening in Newborns: That our AMA-RFS support screening for critical congenital heart defects for newborns following delivery prior to hospital discharge. (Resolution 3, A-18)
- 130.016R** Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients: That our AMA-RFS support working with relevant stakeholders in developing sustainable plans for the appropriate discharge of chronically-homeless patients from hospitals. (Late Resolution 2, I-18)
- 130.017R** Affirming the Medical Spectrum of Gender: That our AMA-RFS: (1) support initiatives that educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (2) affirm that an individual’s genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth. (Late Resolution 3, I-18)
- 130.018R** Increasing Rural Rotations During Residency: That our AMA-RFS support: (1) working with state and specialty societies, medical schools, teaching hospitals, ACGME, CMS and other interested stakeholders to encourage and incentivize qualified rural physicians to serve as preceptors, volunteer faculty, etc. for rural rotations in residency; (2) working with ACGME, ABMS, FSMB, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas; (3) working with interested stakeholders to identify strategies to increase residency training opportunities with a report back to the HOD and formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas. (Resolution 3, I-18)
- 130.019R** Confidentiality of Sexual Orientation and Gender Identity Data: That our AMA-RFS support AMA policy H-65.959, “Opposing Mandated Reporting of People Who Question Their Gender Identity” be amended by addition and deletion to read as follows: “Our AMA opposes mandated reporting or disclosure of patient information related to sexual orientation, of individuals who question or express interest in exploring their gender identity, gender dysphoria, intersex identity, and any information related to gender transition for all individuals, including minors.” (Alt. Resolution 1, A-23)

140.000R HEALTH SYSTEM REFORM

- 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)

- 140.002R** Assessing the Health Care Proposals of the U.S. Presidential Candidates: That our AMA-RFS: (1) request that the AMA collect and disseminate details of the health care proposals of every declared candidate for U.S. President; and (2) that this resolution be forwarded to our AMA House of Delegates every four years prior to every Presidential election. (Resolution 14, A-07)
- 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)
- 140.004R** AMA-Health Care Delivery Task Force: That our AMA-RFS: support the creation of a multi-organizational task force of relevant stakeholders to develop consensus recommendations on a health care system or health care delivery principles that best serve the needs of the American public using the goals and principles of the Health Access America as a starting point. (Substitute Resolution 28, A-97) (Reaffirmed Report C, I-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 H-165.918, 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)
- 140.008R** Legislative Pain Care Restrictions: That our AMA-RFS oppose legislative or other policies that harm patients by restricting their ability to receive effective, patient-specific, evidence-based, comprehensive pain care. (Resolution 2, I-16)

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)

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)

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

150.000R **HEALTH EDUCATION**

150.001R Promoting Prevention Strategies in Waiting Rooms: That our AMA-RFS support the use of interactive media promoting preventive health measures, empowering patients to become more proactive about their health. (Resolution 8, I-06) (Reaffirmed Report D, I-16)

- 150.002R** Public Education About Physicians: That our AMA-RFS support educating the public about the differences in education and professional standards between physicians and other health care providers. (Substitute Resolution 22, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 150.003R** Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients: That our AMA-RFS support: (1) disclosure to cancer patients on risks to fertility when gonadotoxicity due to cancer treatment is a possibility; and (2) education for providers who counsel patients that may benefit from fertility preservation. (Resolution 4, A-18)
- 160.000R** **HEALTH INSURANCE**
- 160.001R** Screening for Pre-Existing Conditions: That our AMA-RFS support health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, with community or modified community rating, in addition to guaranteed renewability. (Resolution 3, A-09)
- 160.002R** Mitigating Abusive Pre-Certification/Pre-Authorization Practices: That our AMA-RFS oppose abusive practices by health insurance entities in pre-certification and pre-authorization of services and medications. (Resolution 15, A-16)
- 160.003R** Individual Responsibility to Participate in Insurance Coverage: That our AMA-RFS support: (1) policies that include personal responsibility to participate in private insurance risk pooling arrangements including financial disincentives (penalties) on persons who choose to forgo coverage until they are sick, (2) that an individual responsibility requirement is necessary to preserve an effective private insurance risk-pool, and (3) support working with stakeholders to explore all options, consistent with the goal of assuring that all Americans have access to health insurance coverage without regard to health status, especially in the event that individual responsibility requirements are overturned by court decisions. (Resolution 3, A-11)
- 160.004R** Use of Confidential Medical Information by Employers: That: (1) the RFS reaffirm its support for AMA Policy H-190.996, Employers' Violation of Patient Privacy with Group Medical Insurance Claim Forms and (2) the RFS Governing Council report back to the Assembly at I-99 on the AMA's advocacy efforts to safeguard patient confidentiality in employer self-insured plans. (Substitute Resolution 13, A-99) (Reaffirmed Report C, I-09)
- 160.005R** Arbitration Agreements: That our AMA-RFS support legislation that would require third party payors to disclose any arbitration agreements to prospective clients prior to, or at the time of enrollment. (Substitute Resolution 26, A-97) (Reaffirmed Report C, I-07)
- 160.006R** Discrimination Against Victims of Domestic Violence: That our AMA-RFS support that health insurance benefits cover conditions arising from injuries associated with domestic violence and prohibit insurance discrimination against victims of domestic

violence and abuse. (Substitute Resolution 10, I-94) [See also: AMA Resolution 402, A-95] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

- 160.007R** Restrictions on Primary Care Physicians in the Delivery of Mental Health and Addictive Services: That our AMA-RFS support equitable payment, by insurance companies, to physicians providing appropriate treatment of mental and addictive illness. (Resolution 11, I-94) [See also: AMA Policy H-185.986] (Reaffirmed Report D, I-16)
- 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)
- 160.009R** Network Adequacy: That our AMA-RFS: (1) support network adequacy as a central element of access to care; (2) support that network adequacy must include emergency and psychiatric care; and (3) oppose out-of-network policies that limit access to care by creating undue financial and administrative burdens for patients and physicians. (Late Resolution 1, I-17)
- 160.010R** Insurance coverage for Additional Screening Recommended in States with Laws Requiring Notification of “Dense Breasts” on Mammogram: That our AMA-RFS support: (1) insurance coverage for supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician; and (2) support insurance coverage for and adequate access to supplemental screening recommended for patients with “dense breast” tissue following a conversation between the patient and their physician. (Resolution 16, A-18)
- 170.000R** **HEALTH WORKFORCE**
- 170.001R** Funding for Preventive Medicine Residencies: That our AMA-RFS support working with the American College of Preventive Medicine, other preventive medicine specialty societies, and other allied partners, to formally support legislative efforts to fund Preventive Medicine Training Programs. (Late Resolution 1, A-05) (Reaffirmed Report E, A-16)
- 170.002R** National Health Service Corps: That our AMA-RFS support sufficient and continuing federal funding of the National Health Service Corps so that it can fully achieve its mission of eliminating health manpower shortages in health professional

shortage areas. (Resolution, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

- 170.003R** National Committee to Evaluate Medical School Closings: That our AMA-RFS support working with appropriate agencies to develop recommendations regarding the number of graduates of U.S. medical schools consistent with appropriate workforce needs. (Substitute Resolution 9, I-97) (Reaffirmed Report C, I-07)
- 170.004R** Resident Training Slots: That our AMA-RFS oppose limitations on the number of residency positions, where such limitations would jeopardize the quality of patient care. (Substitute Resolution 35, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 170.005R** Physicians as National and Regional Health Board Members: That our AMA-RFS oppose components of any health care proposal which excludes practicing physicians as members of national or regional regulatory boards. (Substitute Resolution 20, A-94) [AMA Sub. Res. 127, A-94 was adopted in lieu of Resolution 127 and Resolution 149. See also: AMA Policy H-165.960] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 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) 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]
- 170.007R** Opposition to Deficit Enrollment: That our AMA-RFS endorse the principle that the total number of PGY-1 positions available be greater than the number of first year medical students. (Substitute Resolution 10, I-82) (Reaffirmed Report C, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)
- 170.008R** Preservation of Residency Training Positions: That our AMA-RFS oppose: (1) the dismissal or reassignment of any current resident or fellow as a result of changes in GME funding; and (2) any reduction in the number of future residency and fellowship training positions. (Resolution 5, I-12) (Reaffirmed Report E, A-22)
- 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]

- 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]
- 170.011R** Investigation into Residents, Fellows, and Physician Unions: That our AMA-RFS support the study of the feasibility of a national house-staff union to represent all interns, residents and fellows. (Resolution 14, A-18) (Reaffirmed Resolution 4, A-23)
- 170.012R** Elimination of Non-Compete Clauses in Employment Contracts: That our AMA-RFS support our AMA in the elimination of restrictive not-to-compete clauses within contracts for all physicians in clinical practice, regardless of the for-profit or non-for-profit status of the employer; and that our AMA-RFS support our AMA in strongly advocating for policies that enable all physicians, including residents and fellows currently in training, to have greater professional mobility and the ability to serve multiple hospitals, thereby increasing specialist coverage in communities and improving overall patient care; and that our AMA-RFS support our AMA in asking the Council on Ethical and Judicial Affairs to evaluate amending the AMA Code of Medical Ethics in order to oppose non-compete clauses. (Alt. Resolution 5, A-23)
- 180.000R** **HOSPITALS (SEE ALSO: EMERGENCY MEDICAL SERVICES; HOSPITALS: MEDICAL STAFF)**
- 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]
- 180.002R** Hospital Emergency Codes on ID Badges: That our AMA-RFS support the implementation of mandatory cards containing hospital emergency paging codes be included with the identification badge. (Resolution 2, A-11)
- 180.003R** Non-Medical Indications for Hospitalization: That our AMA-RFS: (1) oppose arbitrary time requirements of inpatient services in determination of eligibility for inpatient, outpatient or extended recovery, rehabilitative, or other post-hospital extended care services; (2) oppose public and/or private insurance statutes, policies, and regulations that require hospitalization longer than medically necessary for determination of benefit eligibility, including eligibility for skilled nursing facility care and other post-hospital extended care services; and (3) support changes in regulations that would include all continuous time spent in the hospital, including time spent in the emergency department, observational status or inpatient status, count requirement, should they exist. (Late Resolution 2, I-15)

190.000R HOSPITALS: MEDICAL STAFF

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 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)

200.000R HOSPITALS: MEDICAL STAFF - ORGANIZATION

210.000R INTERNATIONAL HEALTH

210.001R Support of Protesting Resident Physicians in Poland: That our AMA-RFS support the application of its ideals regarding the health of patients and the rights of physicians in training to all situations where inadequate health care systems and/or injustice exist regardless of national affiliation. (Emergency Resolution 1, I-17)

220.000R INTERNATIONAL MEDICAL GRADUATES

220.001R Employment of Non-Certified Foreign Medical Graduates: That our AMA-RFS: (1) oppose efforts to employ graduates of 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.]

220.002R Restoration of J-1 Visa Waivers for Underserved Communities: That our AMA-RFS support the restoration and maintenance of programs by federal agencies and state governments through which an adequate number of international medical graduates may obtain J-1 visa waivers to provide medical services in underserved communities. (Resolution 10, A-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

220.003R Licensing of International Medical Graduates: That our AMA-RFS, in order to maintain competency of physicians and uphold the quality of medical care, oppose proposals that would establish differential licensing guidelines for international medical graduates, even during periods of unusual migration. (Report I, A-95) [See also: AMA Policy H-255.979, H-255.982, H-255.988] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

220.004R Non-Discriminatory Residency Policy: That our AMA-RFS oppose discrimination in residency applications based solely on country of medical school training. (Substitute Resolution 3, I-88) (Reaffirmed Report C, I-98) [See also: AMA Policy H-255.992] (Reaffirmed Report D, I-16)

- 220.005R** Restriction on IMG Moonlighting: That our AMA-RFS support changes to federal legislation allowing physicians with a J-1 visa in fellowship training programs the ability to moonlight. (Resolution 6, A-18)
- 230.000R** **LEGAL MEDICINE**
- 230.001R** Clinical Implications and Policy Considerations of Cannabis Use: Medicinal Cannabis: That our AMA-RFS support: (1) state and federal based legalization of cannabis for medicinal use; regulation of medicinal cannabis in states that have legalized its use; and (2) funding and other efforts to continue research into the efficacy and side effects of medicinal cannabis use. (Report G, A-16)
- 230.002R** Clinical Implications and Policy Considerations of Cannabis Use: Recreational Cannabis: That our AMA-RFS support: (1) the decriminalization of recreational cannabis; (2) taxation and regulation of recreational cannabis in states that have legalized the sale and use of recreational cannabis; and (3) funding, including the allocation of a portion of cannabis sales tax revenue, toward cannabis abuse education programs, harm reduction strategies, and continued research into public health consequences of recreational cannabis use. (Report G, A-16)
- 230.003R** Clinical Implications and Policy Considerations of Cannabis Use: Medicinal and Recreational Cannabis Use: That our AMA-RFS support public health-based strategies, rather than incarceration, in handling of individuals possessing cannabis for personal use in states where it is not currently legal. (Report G, A-16)
- 230.004R** Advocacy Regarding FICA Taxation for Housestaff: That our AMA-RFS support the AMA studying the consequences of classifying housestaff as either employees or students for the purpose of FICA tax payment and take appropriate action (such as filing an amicus brief in Mayo) on this issue. (Emergency Resolution 1, A-10)
- 230.005R** Eliminating Questions Regarding Marital Status, Childbearing and Dependent Children During the Residency and Fellowship Application Process: That our AMA-RFS (1) oppose questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, and religion and (2) support the AMA working with the ACGME, NRMP and other interested parties to eliminate questioning about marital and dependent status, future plans for marriage or children, sexual orientation, and religion during the residency and fellowship application process. (Resolution 6, I-08)
- 230.006R** Defensive Medicine: That our AMA-RFS: (1) affirm that defensive medicine exists in many forms that have variable and difficult to quantify economic consequences for patients, physicians, third-party payers, insurance providers and other parties involved in the delivery of health care; (2) affirm that defensive medicine in its many forms may result in adverse health effects on patients through exposure to unnecessary risk from tests and procedures as well as limited access to health care resources; and (3) supports the AMA continue to work with other interested parties through legislative and public awareness activities to advocate for medical liability reform which would minimize the practice of defensive medicine. (Report F, A-08)

- 230.007R** Inclusion of Residents in Medical Liability Reform: That our AMA-RFS: (1) support the inclusion of all physicians, including unlicensed residents, in state and federal medical liability caps, (2) support the inclusion of unlicensed residents in all pending and future federal medical liability reform legislation, and (3) support state medical societies advocating for the inclusion of unlicensed residents in all current, pending, and future state medical liability reform legislation. (Report H, I-05) (Reaffirmed Report E, A-16)
- 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)
- 230.009R** Support for Deferred Action Childhood Arrivals (DACA) Medical Students and Physicians: That our AMA-RFS support: (1) the Deferred Action for Childhood Arrivals (DACA) program for current US healthcare professionals, including those currently training as medical students or residents and fellows, who are DACA recipients; and (2) support legislation that protects DACA recipients. (Resolution 12, A-18)
- 230.010R** DACA in GME: That our AMA reaffirm Visa Complications for IMGs in GME D-255.991 and Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986. (Resolution 5, I-18)
- 230.011R** Assessing the Humanitarian Impact of Sanctions: That our AMA-RFS support our AMA in recognizing that economic sanctions can negatively impact health and exacerbate humanitarian crises; and supporting efforts to study the humanitarian impact of economic sanctions imposed by the United States. (Resolution 2, A-22)
- 230.012R** Supporting the Use of Renewable Energy in Healthcare: That our AMA-RFS advocate for the importance of healthcare systems’ timely transition to renewable energy, including wind, solar, geothermal technology, biomass, and hydropower energy; and That our AMA-RFS support implementations of policies and incentives that promote the healthcare sector’s transition to renewable energy. (Resolution 4, I-22)
- 240.000R** **LICENSURE AND DISCIPLINE**
- 240.001R** Telemedicine and Medical Licensure: That our AMA study how guidelines regulating medical licenses are affected by telemedicine and medical technological innovations that allow for physicians to practice outside their states of licensure. (Resolution 4, I-07)
- 240.002R** Independent Regulation of Physician Licensing Exams: That our AMA-RFS support independent oversight of the creation, implementation and regulation of physician licensing exams, paying particular attention to conflicts of interest. (Resolution 1, I-06) (Reaffirmed Report D, I-16)

- 240.003R** Initial State Licensure for Primary Care Physicians: That our AMA-RFS support state medical boards allowing graduates of international medical schools who are in good standing to be able to initiate the medical licensure process no later than the start of their third postgraduate year of clinical training to facilitate timely unrestricted licensure upon completion of residency. (Substitute Late Resolution 5, I-04) (Reaffirmed Report D, I-14)
- 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)
- 240.005R** Resident Fees: That our AMA-RFS: (1) support reducing licensure fees and Drug Enforcement Agency certification fees for resident physicians; and (2) oppose any "provider fees" which would increase the financial burden on resident physicians. (Substitute Resolution 37, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 240.006R** Feedback from Licensing and Board Examinations: That our AMA-RFS support: (1) the Federation of State Medical Boards and the National Board of Medical Examiners providing examinees more detailed and specific performance feedback than currently provided, to allow examinees to identify areas of deficit and to facilitate educational improvement, and (2) all specialty boards providing examinees more detailed and specific performance feedback than currently provided to allow examinees to identify areas of deficit and to facilitate educational improvement. (Substitute Resolution 2, I-00) (Reaffirmed Report C, I-10)
- 240.007R** Reporting Unqualified Residents: That the AMA-RFS support the recommendations in CME Report 8 (A-99), Alternatives to the Federation of State Medical Boards Recommendations on Licensure. (Report I, I-99) (Reaffirmed Report C, I-09)
- 240.008R** National Licensure for Physicians: That our AMA-RFS support the study of the feasibility and implications of national licensure for physicians. (Substitute Resolution 8, I-99) (Reaffirmed Report C, I-09)
- 240.009R** RFS Response to FSMB Recommendations on Licensure: That our AMA-RFS: (1) advocate that successful completion of one year of post-graduate training in an accredited residency program, as certified by the resident's program director, is sufficient to obtain an unrestricted medical license; (2) oppose state medical board oversight of medical students; and (3) in conjunction with the AMA, provide state and local medical societies with supporting materials, including model state legislation, that promotes AMA policy concerning training requirements for unrestricted medical licensure. (Substitute Resolution 6, A-99) (Reaffirmed Report C, I-09)
- 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)

240.011R Resident Physician Licenses: That our AMA-RFS support: (1) the option of limited educational licenses in all states; and (2) reduced licensure fees for resident physicians when a full license is required by a state. (Substitute Resolution 35, I-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

240.012R Postgraduate Training Requirements for Obtaining Permanent Medical Licensure: That our AMA-RFS: (1) support state medical licensing boards permitting graduates of Liaison Committee on Medical Education accredited programs to be licensed for the independent practice of medicine prior to the second year of residency training; and (2) oppose lengthy periods of residency training as part of the requirements for licensure, as tending toward licensure by specialty. (Report J, I-88) (Reaffirmed Report C, I-98) (Reaffirmed Report D, I-16)

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 membership on impairment committees in states where no such representation exists. (Report D, A-83) (Reaffirmed Report C, I-93) (Reaffirmed Report C, I-03) (Reaffirmed Report D, I-13)

240.014R Psychotherapy for Medical Students and Residents: That the AMA-RFS: (1) support the distribution of state medical licensing board requirements for reporting mental health treatment or psychotherapy, and (2) oppose the use of knowledge of mental health treatment or psychotherapy to delay or prevent medical licensing. (Report C, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-16)

240.015R Maintenance of Certification and Maintenance of Licensure: That our AMA-RFS support ongoing efforts to improve Maintenance of Certification/Maintenance of Licensure processes for betterment of residents and fellows entering practice. (Emergency Resolution 1, A-12) (Reaffirmed Report E, A-22)

240.016R Right of a Resident to Practice Medicine within Scope of Practice and Maintain Board Certification: That our AMA-RFS oppose the establishment of scope of practice limitations through use of board certifications by the American Board of Medical Specialties and its member organizations. (Late Resolution 1, A-14)

250.000R **MANAGED CARE**

250.001R CMS, Medicaid, and Health Insurance Corporation Ranking Systems: That our AMA-RFS support ~~current~~ AMA efforts to evaluate and distribute information about individual health insurers, ~~as exemplified by BOT Report 11 (A-08)~~. (Resolution 10, A-08)

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)

250.003R Prohibit MCOs from Requiring Board Passage for Hiring Purposes: That our AMA-RFS support directly advocating to the managed care plans and large employers that contract with those plans, opposition to the use of board certification as the sole criterion for physician acceptance on managed care provider panels. (Substitute Resolution 7, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

250.004R Protection of Residency Education: That our AMA-RFS oppose the role of external financial influence on residency education. (Substitute Resolution 3, A-95) (Reaffirmed Report C, I-05)

250.005R Preserving Residency Training and Board Certification: That our AMA-RFS support: (1) policy to remove board certification as a requirement for enrollment in managed care contracts and to pursue with the insurance industry alternatives to board certification for quality non-boarded physicians; (2) study of alternatives to board certification; and (3) continuation of the requirement of both residency training and a passing score on a board exam in the appropriate specialty for board certification. (Substitute Resolution 4, I-95) [See also: AMA Policy H-275.944] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

260.000R **MEDICAL EDUCATION**

260.001R Eliminating Legacy Admissions: That our AMA-RFS oppose the use of legacy status in medical school application forms. (Resolution 4, A-16)

260.002R Health Policy Education in Medical School and Residency: That our AMA-RFS support developing and incorporating health policy curriculum into medical school, residency, and fellowship. (Resolution 5, I-11) (Reaffirmed Resolution 8, A-12) (Reaffirmed Report E, A-22)

260.003R NRMP All-In Policy: That our AMA-RFS does not support the current “All-In” policy for the Main Residency Match to the extent that it eliminates flexibility within the match process. Also asked that the AMA work with the NRMP, and other external bodies (1) to revise match policy, including the secondary match or scramble process to create more standardized rules for all candidates and (2) to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants. (Report F, A-11)

260.004R Value of Autopsy: That our AMA-RFS supports: (1) that the autopsy continues to be a valuable tool for quality assurance, medical education, determination of cause of death, and accurate reporting of vital statistics, and (2) supports working with the Liaison Committee on Medical Education to encourage all medical schools to include greater exposure to autopsy education as part of the medical school curriculum

including methods of communication with families, education on autopsy technique, and facilitating opportunities to witness a postmortem autopsy. (Resolution 5, A-11)

- 260.005R** Deficiency in Education Related to Autopsy: That our AMA-RFS support studying: (1) areas of deficiency in education relating to autopsy in medical school and residency, in order to identify key interventions in medical education that will have the largest impact in increasing autopsy rates, including, but not limited to, mandating participation in an autopsy during medical school and multiple educational sessions about autopsies for residents, and (2) potential legislative barriers to autopsy and potential efforts to improve autopsy rates. (Resolution 6, A-11)
- 260.006R** Competency-Based Learning Portfolios: That our AMA-RFS support the AMA working with the ACGME and other appropriate bodies to define the usefulness of learning portfolios and their role in medical education. (Report E, I-10)
- 260.007R** Support of Access and Flexibility to Breast Feeding During Required National Medical Exams: That our AMA-RFS support: (1) the provision of additional time during all standardized medical certification and licensing examinations to allow for pumping or nursing a baby per American Academy of Pediatrics recommendations, (2) testing facilities providing a secured, private, and sanitary location separate from lavatory facilities; and (3) that testing locations with these facilities be designated and clearly identifiable at the time of exam registration. (Resolution 2, A-10)
- 260.008R** Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education: That our AMA-RFS support: (1) the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age, (2) students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) the Liaison Committee on Medical Education (LCME) and the Accreditation Council of Graduate Medical Education (ACGME) including LGBT health issues in the cultural competency curriculum for medical education. (Resolution 5, A-05) (Reaffirmed Report E, A-16) (Reaffirmed Report D, I-16)
- 260.009R** Pharmaceutical Federal Regulations – Protecting Resident Interests: That our AMA-RFS oppose federal regulations on the pharmaceutical industry that would curtail educational and/or research opportunities open to residents and fellows that are in compliance with pre-existing AMA ethical guidelines. (Late Resolution 2, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)
- 260.010R** Clinical Skills Assessment as Part of Medical School Standards: That our AMA-RFS support the LCME and AOA modifying their accreditation standards to require that medical schools administer a rigorous and standardized assessment of clinical skills to all students as a requirement for advancement and graduation. (RFS Emergency Resolution 1, I-02; Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

260.011R Clinical Skills Assessment Exam: That our AMA-RFS support:

(1) encouraging state medical licensing boards to collectively exclude the Clinical Skills Assessment Exam (CSAE) from state medical licensure requirements until such time as: (a) the exam has been demonstrated to be statistically valid, reliable, practical and evidence based, (b) scientific studies are published in a peer-reviewed journal justifying the validity of the exam for U.S. medical graduates, (c) a testing site is available in every state with an LCME accredited medical school or within 200 miles of that school, whichever is closer, and (d) scientific studies are published in a peer-reviewed journal demonstrating that the fiscal and societal benefits of this exam equal or outweigh the costs;

(2) encouraging state medical societies to advocate for the collective exclusion of the CSAE from state medical licensure board regulations until such time as: (a) the exam has been demonstrated to be statistically valid, reliable, practical and evidence-based, (b) scientific studies are published in a peer-reviewed journal justifying the validity of the exam for U.S. medical graduates, (c) a testing site is available in every state with an LCME accredited medical school or within 200 miles of that school, whichever is closer, and (d) scientific studies are published in a peer-reviewed journal demonstrating that the fiscal and societal benefits of this exam equal or outweigh the costs;

(3) contacting the National Board of Medical Examiners, all organizations represented on the NBME Governing Board, and the Federation of State Medical Boards to request suspension of the implementation of the proposed mandatory CSAE until such time as: (a) the exam has been demonstrated to be statistically valid, reliable, practical and evidence-based, (b) scientific studies are published in a peer-reviewed journal justifying the validity of the exam for U.S. medical graduates, (c) a testing site is available in every state with an LCME accredited medical school or within 200 miles of that school, whichever is closer, and (d) scientific studies are published in a peer-reviewed journal demonstrating that the fiscal and societal benefits of this exam equal or outweigh the costs; and

(4) commending the Liaison Committee on Medical Education (LCME) for making clinical skill competencies a priority, and work with the Association of American Medical Colleges (AAMC) and LCME to ensure that clinical skill competencies are taught and assessed using standardized patient examinations as part of every medical school curriculum. (Resolution 11, A-02) [See also: HOD Resolution 308, A-02] (Reaffirmed Report D, I-16)

260.012R Endorsement for Appropriate Medical Student Training Conditions: That our AMA-RFS support the development of professional guidelines addressing the issue of appropriate medical student training hours and training conditions during clinical clerkship. (Resolution 3, I-01) (Reaffirmed Report D, I-16)

260.013R Clinical Skills Assessment: That our AMA-RFS support: (1) that all LCME and AMA accredited medical schools comply with the requirement that schools teach and assess clinical skills, and (2) making the Clinical Skills Assessment examination more accessible to International Medical Graduates. (Substitute Resolution 6, A-98) (Reaffirmed Report D, I-16)

- 260.014R** Medical Student Training in Airway Management: That our AMA-RFS support training in techniques and decision making in airway management of the unconscious patient for all medical students as part of their undergraduate medical education. (Substitute Resolution 1, I-97) (Reaffirmed Report C, I-07)
- 260.015R** Establishing Essential Requirements for Medical Education in Substance Abuse: That our AMA-RFS support: (1) that alcohol and other drug abuse education needs to be an integral part of medical education; and (2) the development of programs to train medical students in the identification, treatment and prevention of alcoholism and other chemical dependencies. (Substitute Resolution 31, A-94) [See also: AMA Policy H-295.922] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 260.016R** Providing Residency Applicants a Timely Response to Residency Application Outcome: That our AMA-RFS support: (1) residency and fellowship programs to incorporate interview dates increased flexibility, whenever possible, to accommodate applicants' schedules; (2) the ACGME and other accrediting bodies to require 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]
- 260.017R** Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows: That our AMA-RFS support studying current standards within medical education regarding pathology and laboratory medicine to identify potential gaps in training. (Resolution 7, I-17)
- 260.018R** Evaluation of Changes to Residency and Fellowship Application and Matching Processes: That our AMA-RFS: (1) support proposed changes to residency and fellowship application requirements only when: (a) those changes have been evaluated by working groups which have students and residents as representatives, (b) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (c) There are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of implicit bias that affects medical students and residents from underrepresented minority backgrounds, and (d) the costs to medical students and residents are mitigated; (2) oppose the introduction of new and mandatory requirements that fundamentally alter the residency and fellowship application process until such time as the above conditions are met; and (3) support working with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements. (Resolution 8, I-17)
- 260.019R** Residency Match Systems and Timelines: That our AMA-RFS support: (1) working with all invested stakeholders, specialties and application systems in the residency match, excluding the military match, to support and ensure parity with the match timeline and the ability to couples match by moving towards a unified and

standardized process; (2) working with all invested stakeholders to design a provisional match system whereby medical students matching into preliminary (PGY-1) and, separately, advanced (PGY-2) residency programs match through a staggered system so that the PGY-2 match is timed with the match for all categorical PGY-1 positions and the match for preliminary PGY-1 programs is subsequently delayed to allow for a reduction in application and travel costs with the SOAP to follow the staggered match; and (3) all match application systems providing robust match data to their applicants. (Resolution 11, I-17)

260.020R Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training: That our AMA-RFS support our AMA in working with US Centers for Medicare and Medicaid Services and other relevant stakeholders to create a commission to estimate future physician workforce needs and suggest re-allocation of available residency funding and available first-year positions accordingly; and (2) in working with relevant stakeholders to study the possibility of alternative pathways to ACGME certification of training, ABMS board certification, and medical practice for unmatched medical school graduates. (Alternate Resolution 3, A-22)

260.021R Medical School Management of Unmatched Medical Students: That our AMA-RFS support our AMA to convene a task force of appropriate AMA councils, medical education organizations, licensing and credentialing boards, government bodies, impacted communities, and other relevant stakeholders to:

1. Study institutional and systemic factors associated with the unmatched medical graduate status, including, but not limited to:
 - a) The GME bottleneck on training positions, including the balance of entry-level and categorical/advanced positions;
 - b) New medical schools and the expansion of medical school class sizes;
 - c) Race, geography, income, wealth, primary language, gender, religion, ability, and other structural factors;
 - d) Student loan debt;
 - e) Predatory business practices by medical schools, loan agencies, private equity, and other groups that prioritize profit over student success rates;
 - f) The context, history, and impact of past reports on the state of undergraduate medical education, including the Flexner Report;
 - g) The format and variations of institutional and medical organization guidance on best practices to successful matching;
2. Develop best practices for medical schools and medical organizations to support unmatched medical graduates, including, but not limited to:
 - a) Tools to identify and remediate students at high risk for not matching into GME programs;
 - b) Adequate data on student success rates (e.g., by specialty), and factors associated with success in matching;
 - c) Medical school responsibilities to unmatched medical students and graduates;
 - d) Outcomes-based tuition relief or reimbursement for unmatched students, wherein, unmatched students are returned some component of their tuition to ease the financial burden of being unable to practice clinical medicine;

- e) Transparent, equity-based solutions to address and ameliorate any inequities identified in the match process;
 - f) Alternative, cost-neutral, graduate-level degrees with earlier graduation for students at high risk for not matching;
 - g) Career opportunities for unmatched U.S. seniors and US-IMGs; and
3. Require transparency from stakeholders, including medical schools, about any actions taken based on the report of this task force, particularly with regard to the remediation of medical students. (Resolution 5, I-22)

270.000R MEDICAL EDUCATION: CONTINUING

270.001R Promoting Patient Access to Established Physicians: That our AMA-RFS support: (1) direct patient access to physicians of their choice, regardless of whether the physician is a generalist or specialist; and (2) asking medical specialty organizations to develop guidelines for care provided according to specialty and to document the impact of the guidelines on the quality and cost-effectiveness of direct access to care. (Substitute Resolution 3, A-94) [See also: AMA Policy H-230.999, H-385.992, H-405.985] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

280.000R MEDICAL EDUCATION: FINANCING AND SUPPORT

280.001R Principles of GME Funding Reform: That our AMA-RFS support: (1) that federal funding for Graduate Medical Education (GME) should be based on the actual cost of training residents and fellows (including but not limited to salary, benefits, and institutional support for training and education) and include yearly adjustments for geographic and inflation-based cost-of-living; (2) that the allocation of GME funds within an institution should be transparent and accountable to all stakeholders; (3) that funding for GME should strive to meet the health needs of the public including but not limited to the size of the training program, geographic distribution, and specialty mix; (4) that federal funding for GME from the Centers for Medicare/Medicaid Services or any federal successors should be disbursed through a single transparent funding stream while maintaining opportunities for a multi-payor system; and (5) additional federal funding for the GME that provides flexibility for innovation in training and education above and beyond current levels of funding. (Resolution 20, A-15)

280.002R Making GME Financing and Reform a Priority for AMA: That our AMA-RFS support: (1) that funding for and distribution of positions for graduate medical education (GME) are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (2) expanding medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and (3) making increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda. (Resolution 6, I-11)

280.003R Protecting Graduate Medical Education: Revisiting the All-Payer System: That our AMA-RFS support working together with other stakeholders to actively lobby the current Congress for legislation requiring all payers to contribute towards graduate

medical education, while simultaneously continuing to lobby to protect Medicare and Medicaid Graduate Medical Education payments. (Resolution 7, A-07)

- 280.004R** Securing Medicare GME Funding for Research and Outside Rotations: That our AMA-RFS: (1) support studying current funding mechanisms for residency training programs and potential funding limitations; (2) encourage research and extramural educational opportunities; and (3) oppose work-regulations and funding guidelines which may limit research and extramural educational opportunities during residency training. (Resolution 12, A-07)
- 280.005R** Comparable Financial Support for Residents: That our AMA-RFS support a comparable level of financial support of housestaff positions by level of training within institutions. (Report I, I-95) [See also: AMA Policy H-310.988] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 280.006R** Public Disclosure of Residency Revenue and Expenditures: That: (1) the RFS Governing Council study the feasibility of residency programs obtaining and disclosing revenues and expenditures related to residency training; (2) the RFS Governing Council report to the RFS Assembly at A-99 on current and proposed methodologies of Medicare GME funding; and (3) the RFS report to the Assembly on the feasibility of developing accounting techniques to report the annualized value of resident services. (Substitute Resolution 2, I-98) (Reaffirmed Report D, I-16)
- 280.007R** Compensation for Teaching Physicians: That the AMA oppose the use of Medicare rules regarding reimbursement of teaching physicians for unsupervised services, by private payors and Medicaid unless the payor contributes to graduate medical education on a scale commensurate to Medicare's contribution to graduate medical education. (Report H, A-97)
- 280.008R** Impact of Medicare Regulations on Residency Training: That the AMA-RFS Governing Council continue to: (1) monitor the issue of Medicare, Medicaid, and private payor reimbursement of teaching physicians for supervising residents; and (2) collect information from residents on the regulations regarding reimbursement of teaching physicians for supervising residents and continue to report back to the AMA-RFS Assembly as appropriate. (Report H, I-97) (Reaffirmed Report D, I-16)
- 280.009R** Second Residencies in Primary Care: That our AMA-RFS ask the AMA to seek reinstatement of full Medicare Direct Graduate Medical Education funding training institutions for residents who have completed the minimum years of training for first board eligibility and are seeking a residency in primary care or other shortage specialty, as defined by the Health Care Financing Administration (HCFA). (Substitute Resolution 20, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 280.010R** Support for Combined Residency Programs: That our AMA-RFS support full funding for all years of combined residency training. (Substitute Resolution 18, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

- 280.011R** Medicare Reimbursement of Direct GME Funding: That our AMA-RFS support restoration of Direct Graduate Medical Education funding that allows each resident an initial residency period of five years, regardless of specialty choice or minimum years to attain board certification. (Late Resolution 2, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 280.012R** Reimbursement and Residency Training: That our AMA-RFS support: (1) that residents should be allowed to fully participate in the care of all patients, regardless of reimbursement mechanisms; (2) appropriate reimbursement for services that are provided by residents under the degree of supervision appropriate for the level of training and the educational setting; and (3) that programs must continue to provide appropriate supervision of trainees. (Report E, A-95) [See also: AMA Policy H-310.979, H-310.981] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 280.013R** Compensation for Teaching Staff Physicians: That our AMA-RFS: (1) support appropriate compensation for physician time spent teaching residents, fellows, and students; and (2) oppose any and all sanctions against physicians who see fewer patients and/or perform fewer procedures as a direct consequence of teaching obligations. (Substitute Resolution 30, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 280.014R** Reinstatement of Full Medicare Payment for Second Residencies in Primary Care or Shortage Specialties: That our AMA-RFS support full Medicare Direct Graduate Medical Education reimbursement to training hospitals for residents who have the minimum years of training for first board eligibility and who are seeking to enter a postgraduate training program in a primary care or shortage specialty. (Resolution 37, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 280.015R** Graduate Medical Education Funding: That our AMA-RFS support: (1) monitoring and reporting on Medicare Graduate Medical Education funding; and (2) publicizing and educating trainees on the issue of Medicare GME funding. (Report E, I-91) (Reaffirmed Report C, I-01) [See also: AMA Policy H-305.956] (Reaffirmed Report D, I-16)
- 280.016R** GME Financing: That our AMA-RFS oppose reductions of Medicare funding for graduate medical education. (Substitute Resolution 12, A-91) (Reaffirmed Report C, I-01) [See also: AMA Policy H-305.956] (Reaffirmed Report D, I-16)
- 280.017R** Funding of Education and Research Under Prospective Payment Plans: That our AMA-RFS endorse: (1) the concept that research, development and education are intrinsic components of the "product" medical care and as such, their costs should fairly be assumed by private and public medical insurance programs, health care plans and industry; and (2) asking relevant groups to strive toward a better balance between immediate medical cost containment and long-term concern for medical excellence and progress. (Substitute Resolution 19, A-84) (Reaffirmed Report C, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 281.000R** Medical Education Debt

- 281.001R** Supporting Legislation to Create Student Loan Savings Accounts: That our AMA-RFS support federal legislation creating student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans. (Resolution 5, I-15)
- 281.002R** Loan Repayment for Physicians in Designated Shortage Areas: That our AMA-RFS support: (1) the distribution of information regarding various opportunities surrounding loan repayment through mechanisms including but not limited to: a designated state contact, web resources, and informative meetings, so that residents can make an informed decision regarding employment; (2) tax benefits for physicians who practice in either state-designated or federally-designated shortage areas; and (3) initiatives that facilitate recruitment of physicians to designated shortage areas. (Resolution 8, A-09)
- 281.003R** Expansion of Economic Hardship Loan Deferment: That our AMA-RFS support language advocating for expansion of eligibility for economic hardship deferment for residents and fellows to the greatest degree possible in advocacy activities. (Resolution 2, A-08)
- 281.004R** Alternate Mechanisms for Addressing Medical Debt: That our AMA-RFS support alternate mechanisms that better address the financial needs of post-graduate trainees with educational debt. (Late Resolution 1, I-07)
- 281.005R** Loan Repayment Program Resource: That our AMA-RFS research, compile, and maintain a comprehensive resource to include a hyperlink list of all the loan repayment programs across the country; and that access to this resource be a member-only feature of the AMA website. (Late Resolution 1, A-06) (Reaffirmed Report D, I-16)
- 281.006R** Federal Student Loan Program Interest Rates: That our AMA-RFS: support federal student loan consolidation programs that maximize their effectiveness in addressing medical education debt and patient access to health care. (Substitute Resolution 4, I-04) (Reaffirmed Report D, I-14) [Became HOD Resolution 729: Adopted I-04]
- 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]
- 281.008R** Student Loan Interest Deduction: That our AMA-RFS support: (1) student loan tax relief, and (2) expanding the tax deductibility of student loan interest. (Substitute Resolution 7, A-01) (Reaffirmed Report D, I-16)
- 281.009R** Deferment Period for U.S. Medical School Graduates' Subsidized Federal Stafford Loans: That the AMA-RFS support: (1) expanding economic hardship deferment provisions for trainees for the duration of their postgraduate training; and (2) developing legislation to expand economic hardship deferment provisions for resident and fellow physicians. (Substitute Resolution 1, A-01) (Reaffirmed Report D, I-16)

- 281.010R** Maintaining Financial Solvency During Residency Training: That our AMA-RFS: (1) encourage resident physicians to work with hospitals and universities to examine the issue of student loan indebtedness and possible solutions including increased compensation packages; and (2) continue to work with the AMA to encourage resident physicians to inform legislators of the impact of financing graduate medical education on career choice, specialty choice, and practice location. (Report N, I-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)
- 281.011R** Student Loan Deferment: That the AMA-RFS support: developing a grassroots campaign to educate federal legislators on the expanding burden of medical education debt in an effort to promote the need for extending deferment of student loans for post-graduate training; (2) the AMA lobbying the federal government for legislation that will achieve deferment of medical school loans for the entire residency and fellowship period. (Substitute Resolution 14, A-99; Reaffirmed, Report C, I-09)
- 281.012R** Student Debt: That our AMA-RFS continue to recognize the seriousness of the problem of the expanding burden of medical education debt and elevate to a top legislative priority. (Resolution 8, A-98) (Reaffirmed Report D, I-16)
- 281.013R** Use of Social Security Numbers on Student Loan Accounts: That our AMA-RFS support working with student loan services and other associated agencies to end the use of Social Security Numbers as account numbers. (Substitute Resolution 1, A-98) (Reaffirmed Report D, I-16)
- 281.014R** Deferral and Deduction of Student Loans: That our AMA-RFS support full deferral of medical student loans through the entire duration of training. (Substitute Resolution 15, A-95) [See also: AMA Policy H-305.972] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 281.015R** Administrative Assistance with Medical Education Loans: That our AMA-RFS support all residency training programs providing financial advice and administrative assistance in managing trainee indebtedness. (Resolution 12, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 281.016R** Direct Loan Consolidation Program: That the AMA-RFS support direct loan consolidation programs. (Resolution 9, A-95) [See also: AMA Policy H-305.948] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 281.017R** Student Loan Deferment by Purchasing Institution: That our AMA-RFS support legislation addressing the fact that institutions selling loans do not always forward the original "request for deferment of payment" document to the loan purchasing institution. (Substitute Resolution 14, A-94) [HOD Resolution 210, I-94 was adopted as action, not policy] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 281.018R** Medical School Tuition: That our AMA-RFS support working with all appropriate bodies to study how the cost of medical education to institutions and trainees can be

reduced significantly in coming years. (Substitute Resolution 7, A-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D I-12) (Reaffirmed Report E, A-22)

- 281.019R** Student Loan Deferment During Residency: That our AMA-RFS: (1) support efforts to grant forbearance to residents who request it without penalties, additional costs, or restrictions, but not to the exclusion of deferment; and (2) oppose legislative efforts to curtail or eliminate the classification of residents as students for purposes of loan deferment. (Report D, I-89) (Reaffirmed Report C, I-99) [See also: AMA Policies H-305.965 and H-305.961] (Reaffirmed Report D, I-16)
- 281.020R** Student Loans: That our AMA-RFS support preserving student loan programs for undergraduate medical education. (Resolution 15, A-85) (Reaffirmed Report C, I-95) [See also: AMA Policies H-305.955, H-305.957, H-305.962 and H-305.973] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 281.021R** AMA Participation in Medical Student Debt: That our AMA-RFS support the exploration of the development of an affinity program in which student, resident and fellow members of the AMA could consolidate existing educational loans or obtain new educational loans from one or multiple national banks or other financial intermediaries. (Resolution 4, A-14)
- 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-13) [HOD Resolution 303, A-14]
- 281.023R** Support for the Income-Driven Repayment Plans: That our AMA-RFS support continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden. (Resolution 14, I-17)
- 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

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)

290.000R MEDICAL EDUCATION: GRADUATE

291.000R Resident Work Hours and Conditions

291.001R Improving Physician Well-Being by Exploring Partnerships with Companies that Promote Health and Fitness: That our AMA-RFS support entering into arrangements with companies which promote health and fitness that are willing to provide discounts to AMA-RFS members. (Resolution 4, A-15)

291.002R Evaluation of Resident and Fellow Compensation Levels: That our AMA-RFS support: (1) appropriate protections and increases to resident and fellow compensation and benefits with input from residents and fellows, and other involved parties including residency and fellowship programs; (2) that resident and fellow trainees should not be financially responsible for their training; and (3) establishing consensus regarding the appropriate economic value of resident and fellow services. (Resolution 6, A-15) ((Reaffirmed Resolution 10, I-17)

291.003R Information for Resident Grievances: That our AMA-RFS should include on its RFS website a link to general information and resources addressing resident grievances. (Resolution 8, I-15)

291.004R Protecting Rights of Breastfeeding Residents and Fellows: That our AMA-RFS support: (1) working with key stakeholders, including the ACGME, to mandate language in housestaff manuals or similar policy references of all training programs on the protected time and locations for milk expression and storage of breast milk; and (2) working with key stakeholders, including the ACGME and AAMC, to include language related to the learning and work environments for breastfeeding mothers in regular program reviews. (Resolution 12, A-16)

291.005R Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance: That our AMA-RFS support improved access and reduced barriers to seeking preventive and routine physical and mental health care for trainees in graduate medical education programs. (Resolution 5, A-15)

291.006R Use of Elective Time during Medical Training for Maternity Leave: That our AMA-RFS support: (1) working with appropriate stakeholders such as medical specialty

boards, the ACGME, and RRCs to develop alternative mechanisms for keeping those individuals who have taken family and medical leave on track within their residency and fellowship training so as to abide by their traditional graduation date; and (2) working with appropriate organizations to make the use of elective months more flexible to incorporate the use of this time during family and medical leave. (Resolution 4, I-12) (Reaffirmed Report E, A-22)

291.007R Preserving the Opportunity to Moonlight: That our AMA-RFS support working with appropriate stakeholders including the ACGME, the AOA, and GME programs to discourage denying resident and fellow physicians the opportunity for internal and external moonlighting that complies with current training standards. (Resolution 4, I-11)

291.008R Resident and Fellow Duty Hours and Quality of Training: That our AMA-RFS support the Accreditation Council for Graduate Medical Education (ACGME) to not adopting the IOM report's call for protected sleep periods and for reducing the number of hours that residents can work without time for sleep to 16, until research shows improved patient care and safety; That our AMA encourage the ACGME to allow appropriate flexibility for different disciplines and different training levels within the current ACGME maximum duty hours standards; That our AMA work with other key stakeholders to continue to develop strategies for implementing optimal work schedules to improve resident education and patient safety in healthcare. (Emergency Resolution 2, A-10)

291.009R Resident and Fellow Bill of Rights: That our AMA-RFS support a *Residents' and Fellows' Bill of Rights* that will serve as a testament to the organization's support for and commitment to the education and training of competent, conscientious residents and fellows by illuminating their rights and advocating for provisions that it believes all residents should be afforded, and that have not yet been designated as rights, and that residents and fellows have a right to:

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

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care, including but not limited to membership to medical libraries, remote access to medical journals, and other online or mobile resources; (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings; (6) Financial support or reimbursement for board certification, medical licensing examinations (such as the USMLE STEP 3 or

specialty-specific testing), and educational conferences, to reduce the financial burden residents and fellows face; and (7) Opportunities to advance career development, such as access to leadership roles on hospital committees and adequate paid time off for job and fellowship interviews.

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

With regard to supervision, residents and fellows should expect supervision by physicians and non-physicians who are adequately qualified and which allows them to assume progressive responsibility appropriate to their level of education, competence, and experience. It is neither feasible nor desirable to develop universally applicable and precise requirements for supervision of residents.

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

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

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

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

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal; and c. Recognition as full-time workers and a right to unionize, granting residents and fellows the ability to advocate

collectively to employers and lawmakers on behalf of patients and themselves as workers, not only as learners.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should enable trainees to support their families and pay educational debts, reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living and differences based on geographical location.

(3) With Regard to Benefits, Residents and Fellows Must Be Fully Informed of and Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks without pressure to leave it unused or penalization for its use; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

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

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented; and (3) Adequate hospital staffing and support, including the maintenance of back-up call schedules for every residency program.

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

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

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

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each

semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

2. That our AMA-RFS review and update the Residents' and Fellows' Bill of Rights at a minimum every ten years. (Resolution 1, A-09; Report C, A-21) (Reaffirmed Resolution 4 & 15, A-23)

291.010R Impact of Specialty Board Mandated Residency Completion Dates on Parental Leave During Residency: In order to accommodate leave protected by the federal Family and Medical Leave Act (FMLA), the AMA encourage all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year. (Resolution 2, A-09)

291.011R Provision of Child Care by Residency and Fellowship Training Programs: That our AMA-RFS: (1) begin collecting more comprehensive data on the provision of child care services or stipends for child care by residency and fellowship programs using the Freida database and (2) evaluate the progress made in the provision of child care and different models being utilized by training programs. (Resolution 4, A-08)

291.012R Loss of Status Following Family Medical Leave Act (FMLA) Qualified Leave During Residency Training: That our AMA-RFS: (1) oppose requiring residents to repeat a year of training when returning to work following a leave that qualifies under the federal Family Medical Leave Act; and (2) support the American Board of Medical Specialties and its member boards being in compliance with the Family Medical Leave Act and retracting any policies that do not comply. (Resolution 2, I-07)

291.013R Monitoring of At-Home Call Implementation by Residency Programs: That our AMA-RFS: (1) oppose the use of at-home call if being used to circumvent the intent of current ACGME duty hour restrictions; (2) support working with the ACGME and other interested organizations to collect additional information on how residency programs nationwide are using at-home call rotations; (3) support working with the ACGME and other interested organizations to study the impact of at-home call on resident well-being, sleep patterns, and patient safety, commenting on issues such as, but not limited to, total hours worked, number of pages and phone calls received, and hours of continuous sleep; and (4) support working with the ACGME and other interested organizations to study and develop best practices for implementing at-home call in residency and fellowship programs. (Resolution 3, I-07)

291.014R Resident and Fellow Leave Policy: That our AMA reaffirm existing AMA and AMA-RFS policies on resident and fellow leave. [AMA and AMA-RFS policies reaffirmed in lieu of Res. 5, I-06; See AMA Policies H-420.966, H-420.961, H-

420.987, H-420.967, and AMA-RFS Policies 310.581R, 310.590R, 310.594R, 310.599R, 310.799R] (Report E, A-07)

- 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)
- 291.016R** 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; (3) AMA study, develop, and promote a method of creating an environment for residents to safely report violations on resident duty hours without any repercussions; (4) AMA request 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; (5) AMA continue to work with the ACGME to refine the duty hours standards, and work 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; (6) AMA 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; (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; (8) That our AMA conduct a 10-year survey to capture the attitudes and changes of residents on duty hours after the new ACGME guidelines to determine the effect on working conditions for residents and fellows; (9) That our AMA 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)
- 291.017R** Resident/Fellow Work and Learning Environment: That our AMA-RFS encourages our AMA to continue to: (1) work with other national resident/student organizations to make current hours reform work; (2) explore other options to address compliance with the ACGME Duty Hour requirements including, but not limited to confidential and anonymous reporting and study enforcement alternatives to the current ACGME standards; (3) support the AMA Council on Legislation as the coordinating body in the continued creation of legislative and regulatory options; and (4) work with the AMA Council on Medical Education to address compliance with the ACGME Duty

Hour requirements. (Report F adopted in lieu of Resolutions 4 and 5, I-02)
(Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

- 291.018R** Fellowship Salaries: That our AMA: (1) study the current system of fellowship funding and salaries with a report at I-02, and (2) encourage the ACGME and the ABMS to collect information on fellowship salaries from both accredited and non-accredited programs to serve as a basis for the development of policy recommendations. (Report G, A-02) (Reaffirmed Report D, I-16)
- 291.019R** Resident/Fellow Work and Learning Environment: That: (1) our AMA define resident duty hours as those scheduled hours associated with primary resident or fellowship responsibilities; (2) our AMA support a limit on resident duty hours of 84 hours per week averaged over a two-week period; (3) our AMA 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 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 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 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 support a limit on assignments in high intensity settings of 12 scheduled hours with flexibility for sign off activities; (8) our AMA support that limits on duty hours must not adversely impact the organized educational activities of the residency program; (9) our AMA 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 support that scheduled time providing patient care services of limited or no educational value be minimized; (11) our AMA ask the Joint Commission on the Accreditation of Hospital Organizations (JCAHO) to create new resident work 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 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]
- 291.020R** Resident/Fellow Work and Learning Environment: That our AMA-RFS support that our AMA: (1) may draft original, modify existing, or oppose legislation and pursue any regulatory or administrative strategies when dealing with resident work hours and conditions, (2) work with organizations such as the Accreditation Council for Graduate Medical Education (ACGME), the Joint Commission, and other appropriate organizations, toward finding solutions to the problem of work hours and conditions which would strengthen current work hours enforcement mechanisms, and (3) encourage the Agency for Healthcare Research and Quality (AHRQ) to

examine the link between resident work hours and patient safety and to explore possible solutions to the problem of work hours and conditions. That our AMA-RFS Governing Council report back the RFS Assembly at A-02. (Report F, I-01) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

- 291.021R** Residency Housestaff Leave Requirements: That our AMA-RFS support medical specialty boards adopting the AMA model for residency leave requirements and that this information be provided by residency programs to residents at the time of application for training. (Report E, I-01) (Reaffirmed Report D, I-16)
- 291.022R** Resident and Fellow Work Hours Reform 2001: That: (1) our RFS continue to make the improvement of hospital working conditions, including resident/fellow work hours, a top priority and report back at I-01 regarding the section's progress on this issue, (2) the RFS Governing Council work directly with other interested organizations using forums, workshops, and other methods to address the issue of hospital working conditions and resident/fellow hours, (3) our RFS ask the AMA to have the Council on Medical Education evaluate the scope of work hours violations by residency and fellowship programs and assess the ACGME's progress in curtailing these violations with a report at I-01, (4) our RFS ask the AMA to have the Council on Scientific Affairs work with other appropriate organizations to study the effect of resident/fellow sleep deprivation and fatigue on medical decision making, performance, and medical errors, (5) our RFS ask the AMA to have the Council on Legislation explore legislative strategies to enforce ACGME resident/fellow work hour standards and study the potential impact of state/federal legislation on work hours and teaching institutions with report back at I-01, (6) our RFS ask the AMA to have the Council on Medical Service study the feasibility of enforcement of resident/fellow work hour standards by state/federal regulatory agencies, and (7) our AMA Board of Trustees review recent activities by the AMA and other organizations related to resident and fellow working conditions reform and report back at I-01. (Report F, A-01) (Reaffirmed Report D, I-16)
- 291.023R** Intern and Resident Work Standards: That our AMA-RFS support: (1) various ACGME-RRC standards as a template for reasonable resident work conditions; (2) the development of effective sanctions for violation of ACGME resident work standards; and (3) publishing the list of programs with work hour violations in print and in electronic form. (Substitute Resolution 1, I-00) (Reaffirmed Report C, I-10)
- 291.024R** Data Bank for Poor Outcomes Associated with Excessive Work Hours: That our AMA-RFS support: (1) the development of an anonymous reporting network for adverse outcomes associated with working conditions and the work environment, including excessive work hours and (2) national surveys of resident work hours and working conditions in order to develop recommendations regarding work hours and working conditions to optimize resident education and patient care. (Substitute Resolution 5, I-98) (Reaffirmed Report D, I-16)
- 291.025R** Support for Night Float Rotation: That our AMA-RFS support: (1) alternatives to the traditional night call system in undergraduate and graduate medical education training; and (2) the elimination of any RRC guidelines that discourage alternatives

to traditional night call such as night float. (Substitute Resolution 10, A-98)
(Reaffirmed Report D, I-16)

291.026R Supervision of Residents: That our AMA-RFS support Medicare reimbursement for teaching physicians to ensure (1) more reasonable documentation requirements, (2) clarify and determine reasonable physical presence requirements, (3) expand the limited exception requirements for attending physician supervision to restore training for non-primary care residents at centers located in outpatient centers regardless of hospital affiliation. (Report F, A-97) (Reaffirmed Report D, I-16)

291.027R Extended Leave Policy for Residents: That our AMA-RFS support the ACGME and employers providing extended leave of up to one year for resident physicians with extraordinary and long term personal or family medical tragedies without the loss of previously accepted residency training positions. (Substitute Resolution 11, A-97)
(Reaffirmed Report C, I-07)

291.028R Misrepresentation of Degree of Supervision: That our AMA-RFS: (1) reaffirm support of appropriate supervision of residents and (2) support the AMA in its continued efforts to work with and monitor HCFA's implementation of the new Teaching Physician Guidelines. (Substitute Resolution 2, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

291.029R Reallocation of Residency Positions and Preservation of Work Hour Reform: That our AMA-RFS supports the study of potential adverse effects from redistribution or reduction of residency positions on residency education, work hours, and conditions. (Substitute Resolution 19, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

291.030R Resident Work Hours: Recommended that our AMA-RFS Governing Council continue to monitor resident working conditions, including working hours, and report back to the Assembly as appropriate. (Report G, I-95) [See also: AMA Policy H-310.957, H-310.979, H-310.981] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

291.031R Sick Leave for Resident Physicians: That our AMA-RFS: (1) oppose the inappropriate use of sick leave in the workplace; and (2) support allowing residents to be absent for illness or surgery for a reasonable period of time without being penalized, within the parameters of the Accreditation Council of Graduate Medical Education (ACGME) and Residency Review Committee (RRC) requirements. (Substitute Resolution 2, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16) ((Reaffirmed Resolution 6, I-17)

291.032R Residency Working Hours: That our AMA-RFS support alternatives to the traditional night call system in undergraduate and graduate medical education training to ensure quality patient care and sustain good health for physicians in training. (Substitute Resolution 34, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

- 291.033R** Recognition and Definition of Resident Abuse: That our AMA-RFS: (1) recognize resident abuse as a valid issue and apply the definition established for medical student abuse to residents; and (2) support further research on medical student and resident abuse. (Substitute Resolution 17, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 291.034R** Residents' Benefits: That our AMA-RFS support ongoing long-range planning and strategy development to improve the vocational, personal, and educational benefits of residents. (Substitute Resolution 1, A-81) (Reaffirmed Report C, I-91) (Reaffirmed Report C, I-01)(Reaffirmed Report D, I-16)
- 291.035R** Evaluating the Effect of ACGME Resident Work-Hours Reforms: That our AMA-RFS support: 1) studying the impact of duty-hour changes on the quality of patient care and on resident and fellow education and well-being and to evaluate the strategies implemented by graduate medical education programs and hospitals to optimize patient care and graduate medical education in light of the duty-hour changes; and 2) that the ACGME only introduce new duty-hour rules if they are evidence-based. (Resolution 10, A-12) (Reaffirmed Report E, A-22)
- 291.036R** Transparency on Maternity and Paternity Leave Policies for Trainees: That our AMA-RFS supports all medical education and training programs making maternity, paternity, and adoption leave policies transparent and readily available to any applicant in a manner which unequivocally states if and how leave may be taken for these events without incurring extension of training. (Resolution 3, A-13) [HOD Resolution 305, A-14] (Reaffirmed Report D, I-16)
- 291.036R** Strategies to Reduce Burnout in Medical Trainees: That AMA-RFS policy Intern and Resident Burnout 291.015R be reaffirmed. (Resolution 8, I-18)
- 291.037R** Residency and Fellowship Program Director, Assistant/Associate Program Director, and Core Faculty Protected Time and Salary Reimbursement: That our AMA-RFS support amending the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or “protected time” for resident and fellow education by “core faculty,” program directors, and assistant/associate program directors. (Resolution 10, A-19)
- 292.000R** Grievances and Due Process
- 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;
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 attorney, in a timely manner prior to the hearing;
 6. Program directors and residents should have the right to be represented by an attorney during review hearings. Program directors, residents, or their respective attorneys should be permitted to call and examine/cross-examine witnesses and present evidence during the review hearing;
 7. Program directors, residents, or their respective attorneys should receive a written statement of the review committee's recommendation and the basis for the decision;
 8. Residency program disciplinary policies should state whether a resident will continue to receive their compensation pending a final decision on any disciplinary action;
 9. Residency program disciplinary policies should include a reasonable process by which residents can obtain their training record for any reason. (Report E, I-13)

- 292.002R** Protection of Peer Review Evaluations During Litigation: That our AMA-RFS oppose the utilization of resident and fellow performance evaluations for any purpose other than providing educational feedback. And that our AMA-RFS specifically opposes utilization of any evaluations of resident and fellow performance during a litigation process. (Resolution 5, A-09)
- 292.003R** Appropriate Use of 360-Degree Resident Evaluations: That our AMA-RFS support working with the Accreditation Council on Graduate Medical Education to: (1) study mechanisms used by residency programs to evaluate resident performance in the ACGME six general competencies, including 360-degree evaluation tools, and (2) develop standards for the use of 360-degree evaluations, including a determination of their validity in resident assessment, and methods to ensure that the content of individual evaluations remains confidential and legally protected. (Resolution 4, I-09)
- 292.004R** Improving Resident, Fellow and Patient Safety: That our AMA-RFS supports the Accreditation Council for Graduate Medical Education (ACGME) and American Osteopathic Association (AOA): (1) creating and maintaining an anonymous system for reporting duty hour violations and resident intimidation in order to protect residents, fellows, and patients by improving compliance with the common residency program requirements established by the ACGME; (2) distributing information to residents at orientation on the known dangers of duty hour violations, the avenues available to report such violations, and the processes that the ACGME uses to bring programs who violate duty hour rules into compliance; (3) creating and maintaining a system of incentives and disincentives for programs to comply with the common

residency program requirements in addition to the threat of loss of accreditation; and (4) creating and maintaining a system that will protect whistleblowers from retribution for reporting duty hour violations. (Resolution 2, I-06) (Reaffirmed Report D, I-16)

- 292.005R** Increasing Resident and Fellow Awareness of Local Representation: That our AMA-RFS support the ACGME requiring institutions to annually disseminate to all residents and fellows the current full-text institutional due process rules for residents and fellows and the current names and contact information of residents serving on hospital committees and the responsibilities of their respective committees. (Substitute Resolution 5, A-00) (Reaffirmed Report C, I-10)
- 292.006R** Due Process for Housestaff in All Loss-of Employment Situations: That our AMA-RFS support proposed modifications to the ACGME Institutional Requirements that would expand the provision of a grievance process to situations including non-renewal of contract and other actions that would threaten the career of a resident physician. (Substitute Resolution 2, A-00) (Reaffirmed Report C, I-10)
- 292.007R** Evaluations and Consultations for Use in Grievance Procedures: That our AMA-RFS: (1) ask the AMA's Council on Ethical and Judicial Affairs to develop guidelines for residency programs regarding the procedures by which a residency program can terminate or dismiss a resident; and (2) publicize current CEJA opinions that relate to residency termination hearings. (Report J, I-97) (Reaffirmed Report D, I-16)
- 292.008R** Confidential Resident Complaint Procedure: That our AMA-RFS support mandatory RRC use of annual anonymous resident surveys prior to site visits, and that the AMA-RFS continue to pursue mechanisms for resident input into the program review process. (Report J, A-95) [See also: AMA Policy H-310.995] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 292.009R** Due Process Grievance Procedures, and Graduate Medical Education Reform: That: (1) The AMA-RFS periodically distribute information on due process and contract agreements as outlined by the ACGME, AMA, and AMA-RFS to residents via AMA-RFS publications; and (2) The AMA distribute AMA's publication, Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures to Chairmen of residency training program's graduate medical education committees and housestaff associations. (Report E, A-92) (Reaffirmed Items 1 and 2, Report C, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)
- 292.010R** Due Process System for Residency Programs: That the AMA-RFS maintain the following principles for due process system-for residency programs: (1) A personal record of evaluation should be maintained for each resident which is accessible to the resident. (2) A resident should have the opportunity to challenge the accuracy of the information in his/her resident record. (3) At least annually, but preferably semi-annually, the program director and teaching staff should evaluate each resident's performance and provide each resident with this evaluation. (4) Each resident should expect to continue to the next level of training, unless he/she is given adequate notice and informed of reasons he/she may not so advance. (5) Residents should be

involved in the development of recommendations on policy issues, involving education and patient care including the mechanism for evaluation or resident performance. (6) There should be policies and procedures that define the bodies responsible for evaluation of residents and the function and membership of such bodies. These policies and procedures should provide for timely and progressive verbal and written notification to the physician that his/her performance is in question, and provide an opportunity for the resident to learn why it has been questioned. (7) There should be participation by residents in all institutional bodies involved in the evaluation of residents. Consideration should also be given to including staff physicians closely involved in housestaff interactions. Those residents participating should have full voting rights. Representatives of the housestaff should be selected by members of the housestaff. (8) These policies and procedures should also provide that when a resident has been notified of an adverse action, he/she has adequate notice and opportunity to appear before a decision making body to respond to the charges and introduce his/her own rebuttal. Dismissal from the program, the replacing of the resident on probation or otherwise depriving the resident of the property rights to which he/she is entitled in order to continue in the program constitutes an adverse action. 9) The fundamental aspects of a fair hearing are: a listing of specific charges, adequate notice of the right to a hearing, the opportunity to present and to rebut the evidence, and the opportunity to present a defense. (10) A hearing should be conducted and a decision reported to the resident in a timely manner thereby minimizing interruption of the resident's training. (11) The resident should be permitted to be accompanied by another physician or advisor at the hearing of his/her choice. (12) A record of the hearing should be made and retained for review by interested parties who have obtained the written consent of the resident. (13) The policies and procedures should include an appeal mechanism within the institution. (14) All matter upon which the decision is based must be introduced into evidence at the proceeding before the hearing committee in the presence of the resident. An appeal of the decision of the hearing is limited to matters introduced at the hearing and made available to the resident. (15) Pending a final decision of the adverse action by the appellate body for the program, the resident should be permitted to continue in the training program except in the extraordinary case where patient safety and well being would be in jeopardy in the hospital. (Report C, A-82) (Reaffirmed Report C, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-16)

292.011R Bereavement Leave for Medical Students and Physicians: That our AMA-RFS support the AMA supporting 'Bereavement Leave for Medical Students and Physicians': 1) Our AMA urges medical schools, residency and fellowship training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of bereavement leave policies as part of the physician's standard benefit agreement; 2) Recommended components of bereavement leave policies for medical students and physicians include: a) 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 bereavement leave policies a three-day minimum leave with the understanding that no physician or medical student should be required to take minimum leave. 4) Medical students and physicians who are unable to work beyond the defined bereavement leave period because of physical or psychological stress, medical complications of pregnancy loss, or another related reason should refer to their institution's sick leave policy, family and medical leave policy, and other benefits on the same basis as other physicians who are temporarily unable to work for other reasons. 5) Our AMA supports the concept of equal bereavement leave for pregnancy loss and other such events impacting fertility in a physician or their partner as a benefit for medical students and physicians regardless of gender or gender identity. 6) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs. 7) These guidelines as above should be freely available online and in writing to all applicants to medical school, residency, or fellowship. (Resolution 1, I-21)

292.012R Affirmatively Protecting the Safety and Dignity of Physicians and Medical Students as Workers: That our AMA-RFS support the AMA in reviewing reports of unsafe working conditions and unfair retaliation for public expression of safety concerns on the part of physicians and trainees and consider methods to provide logistical and legal support to such aggrieved parties; and developing and distributing specific guidelines on how physicians and trainees may make public comments on working conditions and legal options to promote workplace safety (e.g. filing formal OSHA complaints), as well as other workplace protection issues as appropriate; and amending AMA policy H-440.810 to read:
3. Our AMA will AMA advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need. 4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty. 5. Our AMA supports a physician's right to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster; resident physicians and medical students must have the right to participate in public commentary addressing the adequacy of resources for their own safety in such conditions; and supporting legislation and other policies protecting physicians and medical students from violence and unsafe working conditions. (Resolution 12, I-21)

293.000R Collective Negotiations and Housestaff Organizations

293.001R Physician Scientist Benefit Equity: That our AMA-RFS support the concept that all resident and fellow physicians who function in a role as physician scientists are

provided with benefits packages comparable to those provided to their peers in clinical residencies or fellowships. (Resolution 1, A-07)

293.002R Resident Pay during Orientation: That our AMA-RFS support: (1) that all resident and fellow physicians should be compensated, and receive benefits, at a level commensurate with the pay that they will receive while in their training program, for all days spent in orientation activities prior to the onset of their contractual responsibilities; (2) the ACGME amending its Institutional Requirements so that institutions are required to compensate resident and fellow physicians, and provide benefits, for time spent in orientation activities at a level commensurate with the pay that the resident or fellow shall receive while in their program. (Resolution 4, I-06) (Reaffirmed Report D, I-16)

293.003R Eliminating Benefits Waiting Periods for Residents and Fellows: That our AMA-RFS support: (1) the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training; (2) asking the Accreditation Council on Graduate Medical Education (ACGME) to clarify its institutional requirement to provide hospital, health, and disability insurance to residents, fellows and their families from the first day of orientation, and further petition the ACGME to aggressively enforce this requirement; and (3) working with the ACGME & Liaison Committee on Medical Education (LCME) to develop policies that ensures continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into Graduate Medical Education. (Resolution 4, A-06) (Reaffirmed Report D, I-16)

293.004R Housestaff Organizations: That our AMA (1) continue to support the development of independent housestaff associations as one option for resident and fellow physicians who wish to organize and advocate to improve or affect the quality of patient care; (2) be prepared to implement a national labor organization specifically for all eligible resident and fellow physicians at such time as the National Labor Relations Board determines that resident and fellow physicians are authorized to organize a bargaining unit under the National Labor Relations Act; and (3) continue to vigorously support antitrust relief that would permit collective bargaining between groups of self-employed physicians and health plans/insurers/hospitals, and be prepared to implement a national labor organization for these physicians should antitrust relief occur. (Report F, A-99) (Reaffirmed Report C, I-09)

293.005R Annual Contracts for Continuing Residents: That our AMA-RFS support the ACGME to requiring residency programs to provide their continuing residents with an annual written contract no later than March 1. (Substitute Resolution 12, I-98) (Reaffirmed Report D, I-16)

293.006R Collective Negotiations by Residents: That our AMA ask its representatives to the ACGME to continue their diligence in supporting inclusion of the following AMA proposed amended language into Section 1,B,3,e(1) of ACGME's Institutional Requirements:

Section 1,B,3,e(1) Provision of an organization system for communication and resolution of resident concerns on all issues pertaining to resident educational

programs, patient care and resident well being. Institutions must allow resident physicians the ability to form a resident organization and use it or other forums to facilitate regular assessment of resident concerns; (2) that the AMA approve a nationwide program offering supporting materials and telephone and on-site assistance to groups of residents seeking to form independent housestaff organizations advocating no actions resulting in withholding care; and (3) that the AMA study the potential effects on future resident demand for housestaff associations or unionizations should the NLRB rule that all residents are subject to legal protections under the NLRA and make recommendations as to ways in which the AMA can appropriately address those demands. (Report F, A-98)

- 293.007R** Collective Negotiations by Residents: That: (1) our AMA-RFS endorse the principles adopted by the AMA Board of Trustees regarding changes in the Accreditation Council for Graduate Medical Education (ACGME) Institutional Requirements regarding collective negotiation for residents; (2) that the AMA seek to amend the ACGME Institutional Requirements to include the following: a) prohibit a teaching institution from impeding any efforts by the residents to create a residency organization b) require teaching institutions to engage in good faith collective negotiations with resident organizations on issues of patient care and resident well-being c) forbid teaching institutions from retribution against individual residency for activity related to a resident organization; (3) that the AMA seek means to ensure enforcement of Institutional Requirements by ACGME; (4) that the AMA prepare an amicus brief for the National Labor Relations Board (NLRB) in support of the right of resident organizations to collectively negotiate with teaching institutions but opposed to actions that would withhold patient care; (5) that the AMA vigorously pursue legislation to amend the NLRB Act to create a special student-employee classification for residents that would grant resident organizations the ability to participate in binding collective negotiation without the ability to withhold medical care as a work action; (6) that the AMA provide sufficient resources through its Division of Representation to prepare resident organizational models and provide adequate staff support to resident as well as other physician groups seeking to form organizational entities. (Report F, I-97) (Reaffirmed Report D, I-16)
- 293.008R** Exposure to Residency Contracts for First Year Residents Prior to Match Day: That our AMA-RFS support the Accreditation Council on Graduate Medical Education (ACGME) requiring programs to provide representative first year contracts to medical students interviewing for positions within their program prior to the submission of rank list. (Substitute Resolution 15, A-97) (Reaffirmed Report C, I-07)
- 293.009R** Rules for Resident Negotiations: That our AMA-RFS support the development of appropriate guidelines for addressing and negotiating contract and employment disputes which affect trainees as a group. (Resolution 18, A-97) (Reaffirmed Report C, I-07)
- 293.010R** Impact of Healthcare Merging on Residents' Welfare: That our AMA-RFS: (1) strongly oppose any compromise of residents' contractual rights or benefits, which would be affected by the merging of institutions; (2) support the right of resident representatives to be present at all negotiations involving residents' contractual rights

or benefits; and (3) support documentation and publication of any infractions upon contractual rights of residents as a result of the mergers. (Substitute Resolution 27, A-95) [See also: AMA Policy H-310.999] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

293.011R Benefit Packages for Resident Physicians: That our AMA-RFS support that: (1) all institutions be required to provide their resident physicians with disability insurance, life insurance, HIV indemnity, malpractice insurance including tail coverage, retirement benefits, health, sick leave and wages commensurate with their education and experience; and (2) if a given benefit or salary is provided to some residents within a given program at the same postgraduate level, then that benefit must be provided to all residents, but this provision should not be used to eliminate the benefit in question. (Substitute Resolution 13, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

293.012R Analysis of Antitrust Legislation Regarding the AAMC, ACGME, NRMP, and other Relevant Associations or Organizations: That our AMA-RFS support efforts which seek to weaken the antitrust exemption for graduate medical education programs and the MATCH as stated in Section 207 of the Pension Funding Equity Act of 2004; and That our AMA-RFS support our AMA in studying alternatives to the current residency and fellowship MATCH process which would be less restrictive on free market competition for applicants. (Report A, I-22)

294.000R Residency Programs: Curriculum and Training

294.001R Telemedicine in Graduate Medical Education: That our AMA-RFS: (1) support educating resident and fellow physicians on the use of tele-health technology in their future practices; and (2) studying the barriers to optimizing the use of tele-health technology for the purposes of tele-education and specifically tele-precepting in Graduate Medical Education and the solutions to overcoming these barriers. (Resolution 16, A-15)

294.002R Primary Care and Mental Health Training in Residency: That our AMA-RFS support: (1) the incorporation of integrated mental health and primary care services into existing psychiatry and primary care training programs' clinical settings; That our AMA encourage primary care and psychiatry residency training programs to create and expand opportunities for residents to obtain clinical experience working in an integrated mental health and primary care model, such as the collaborative care model; That our AMA advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings. (Resolution 13, A-16)

294.003R Improving Access to Care and Health Outcomes: That our AMA-RFS support training opportunities for students and residents to learn cultural competency for community health workers. (Resolution 16, A-16)

294.004R Report on the Deficiency in Medical Education Relating to Autopsy: That our AMA-RFS support: 1) working with all relevant organizations to advocate for participation in an autopsy during medical school or residency training and to

overcome legislative and other barriers to improving autopsy rates; and 2) working with all relevant parties to develop a standard a model curriculum or teaching module on discussion of autopsy, obtaining consent, and autopsy results as part of a patient care specialty. (Report G, I-11)

- 294.005R** ACGME Allotted Time off for Health Care Advocacy and Policy Activities: That our AMA-RFS urge the ACGME to acknowledge that "activities in organized medicine" facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; That our AMA encourage all residency and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; That our AMA encourage the ACGME to adopt policy that every resident and fellow be allotted additional of time per year, beyond of scheduled vacation time, to be used for activities of organized medicine, including but not limited to, health care advocacy and health policy; That our AMA study the other barriers and possible options to overcome these barriers to resident and fellow involvement in of organized medicine, including but not limited to, health care advocacy and health policy. (Resolution 6, A-10)
- 294.006R** Knowledge of Medical Costs Among Residents and Fellows in Training: That our AMA-RFS support the integration of cost-effectiveness education into medical training, including how to analyze and apply cost-effectiveness data to medical decision-making; That our AMA work with the ACGME and other appropriate bodies to incorporate cost-effectiveness education into medical training, including how to analyze and apply cost-effectiveness data to medical decision-making in residency and fellowship training programs. (Report G, A-10)
- 294.007R** Evaluation of Increasing Residency Review Committee (RRC) Requirements: That our AMA study residency/fellowship documentation requirements for program accreditation and their impact on program directors and residents with recommendations for improvement. (Substitute Resolution 9, A-07)
- 294.008R** Membership List Access: That our AMA-RFS: (1) support working closely with the National Resident Match Program (NRMP) to explore faster delivery of the NRMP match list to the AMA; (2) support the AMA reviewing its internal processing of the National Resident Match Program match list in order to improve delivery time to interested parties; and (3) support working with state societies to ensure data license agreements and contact information are up-to-date. (Report H, A-05) (Reaffirmed Report E, A-16)
- 294.009R** Membership List Access: That the AMA-RFS Governing Council: (1) work with the AMA to facilitate expedited access by the state medical associations to the NRMP match list; and (2) explore additional mechanisms outside the NRMP match list to obtain new resident information for the AMA-RFS and individual state medical associations. (Substitute Late Resolution 7, I-04) (Reaffirmed Report D, I-14)
- 294.010R** Fellowship Application Reform: That our AMA-RFS: (1) support the development of a standardized application and selection process for each fellowship training specialty, specifically to simplify the process of application for subspecialty training;

and (2) support that residents are allowed adequate exposure to subspecialty training prior to the initiation of the fellowship application process. (Resolution 1, A-04) (Reaffirmed Report D, I-14) [See also AMA HOD Resolution 323, A-04]

- 294.011R** Training in Reimbursement Coding in Residency Programs: That our AMA encourage training in practice management, including training on proper reimbursement coding and documentation to better prepare residents for medical practice. (Substitute Resolution 3, A-98) (Reaffirmed Report D, I-16)
- 294.012R** Education and Regulation of Electrologists: That our AMA-RFS support the appropriate agencies to establishing regulatory and practice guidelines for electrologic procedures including education in the prevention of disease transmission during hair removal procedures. (Substitute Resolution 1, A-97) (Reaffirmed Report C, I-07)
- 294.013R** ACLS Training for Residents: That our AMA-RFS support the ACGME to requiring programs to provide (finance, arrange, and record) current certification in specialty-congruent advanced life support before allowing residents to participate in patient care rotations. (Report J, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 294.014R** Americans with Disabilities Act and Resident Training Files: That our AMA-RFS support working with appropriate entities to ensure that all residency program directors and department chairs are advised of the Americans with Disabilities Act (ADA) and its legal ramifications pursuant to disclosure of training files. (Resolution 7, A-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 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)
- 294.016R** Support for Women's Health: That our AMA-RFS support efforts to promote the multidisciplinary incorporation of women's health education, research and training across all medical specialties and in medical school, residency training, and continuing medical education. (Substitute Resolution 11, I-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 294.017R** Access to Medication and Procedural Abortion Training: That our AMA-RFS: (1) support the opportunity for residents to learn medication and procedural abortion; (2) oppose efforts by other persons, governments, or organizations to interfere with or restrict the availability of training in medication and procedural abortion; and (3) in the event that medication and procedural abortion are limited or otherwise unavailable at a home institution, supports cost subsidization for trainees traveling out-of-state and/or to another program to have hands-on training in medication and procedural abortion. (Substitute Resolution 25, I-94) [See also: AMA Policy H-295.923] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16) (Modified: Resolution 6, I-22)

- 294.018R** Cardiopulmonary Resuscitation Certification for Residents and Other Physicians: That our AMA-RFS support competency in basic CPR during residency training. (Substitute Resolution 13, I-78) (Reaffirmed Report C, I-88) (Reaffirmed Report C, I-98) [See also: AMA Policy H-130.997] (Reaffirmed Report D, I-16)
- 294.019R** Mitigation of Physician Performance Metrics on Trainee Autonomy and Education: That our AMA-RFS support mitigating the negative effects of physician performance metrics on trainee autonomy and clinical experience during residency and fellowship training. (Resolution 7, I-14)
- 294.020R** Scholarly Activity by Resident and Fellow Physicians: That our AMA-RFS support: (1) defining resident and fellow scholarly activity as any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge, including but not limited to peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity; and (2) our AMA working with partner organizations to ensure that residents and fellows are able to fulfill scholarly activity requirements with any rigorous, skill-building experience approved by their program director that involves the discovery, integration, application, or teaching of knowledge including but not limited to peer-reviewed publications, national leadership positions within health policy organizations, local quality improvement projects, curriculum development, or any activity which would satisfy faculty requirements for scholarly activity. (Resolution 13, A-18)
- 294.021R** Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education: That our AMA-RFS support our AMA in continuing 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; and encouraging education on the benefits of evidence-based Osteopathic Manual Therapy for musculoskeletal conditions in medical education of allopathic students and in primary care residencies. (Report D, A-22)
- 294.022R** Support for GME Training in Reproductive Services: That our AMA-RFS supports our AMA in amending policy H-295.923, “Medical Training and Termination of Pregnancy,” by addition and deletion to read as follows:
 Medical Training and Termination of Pregnancy
 1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.
 2. Our AMA supports will advocate for the availability of abortion education and hands-on exposure to medication and procedural abortion ~~procedures for termination of pregnancy, including medication abortions,~~ for medical students and

resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.

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

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

That our AMA-RFS support our AMA in reaffirming policies H-100.948 "Supporting Access to Mifepristone (Mifeprex)" and H-425.969 "Support for Access to Preventive and Reproductive Health Services." (Resolution 6, I-22)

294.023R Residents Verification of Training and Credentials: That our AMA-RFS support our AMA in reaffirming Policy H-225.950, "AMA Principles for Physician Employment." (Resolution 15, A-23)

295.000R **Residency Programs: Accreditation and Evaluation**

295.001R Transparency in Consumer Communications: That our AMA-RFS support: 1) an Federal Trade Commission (FTC) investigation of whether advertising which refers to certain "board certifications" is false and misleading under the FTCA and FTC regulations when it refers to boards that are so-called "knock-off boards," (i.e. those which have weak certification standards and give the false appearance of certification by a competent certifying body); and 2) language from section 4(a) of the current AMA Truth in Advertising Campaign model bill being added to current legislation on health care transparency. (Resolution 9, I-11)

295.002R Protection Against delayed Residency Program Closure: That our AMA-RFS: (1) support medical specialty boards adding delayed residency program closure to its list of exceptions to the continuity of care guidelines, expanding the definition of hardship to allow residents to transfer to another residency program for completion of board eligibility requirements, (2) support each Residency Review Committee performing timely emergency site visits to any residency program announcing delayed closure to ensure compliance with Accreditation Council for Graduate Medical Education (ACGME) established accreditation guidelines, and (3) support each Residency Review Committee closely monitoring any residency program in delayed program closure to ensure continued compliance with the ACGME guidelines and ensuring appropriate sanctions are imposed, including possible immediate closure of the residency program, if these guidelines are transgressed. (Amended Resolution 2, I-04) (Reaffirmed Report D, I-14) [See also: AMA Policy D-310.972]

- 295.003R** Publishing Evaluations of Residency Programs: That our AMA-RFS: (1) support asking the ACGME to publish the accreditation letter sent to each program reviewed by an RRC that includes the length of approved accreditation and the programs strengths and weaknesses, and response prepared by the program to the accreditation letter; (2) ensure that accreditation actions are presented in an accessible and understandable format on AMA FREIDA; and (3) support the AMA request to the ACGME to require anonymous surveys of residents. (Report G, A-00) (Reaffirmed Report C, I-10)
- 295.004R** Minimum Resident Benefits: That our AMA-RFS continue to monitor the revision of the "General Requirements" of the Essentials of Accredited Residencies in Graduate Medical Education for significant changes in benefits language, and act on them as appropriate within current AMA-RFS actions and AMA policies. (Report I, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09)
- 295.005R** Displaced Residents: That our AMA-RFS support the ACGME streamlining the process through which displaced residents can enter other residency programs. (Substitute Late Resolution 2, I-99) (Reaffirmed Report C, I-09)
- 295.006R** Enforcement of ACGME Requirements: That our AMA study and report back on methods the ACGME could use, in addition to probation and withdrawal of accreditation, to enforce its Institutional Requirements and RRC Program Requirements. (Substitute Resolution 11, A-99) (Reaffirmed Report C, I-09)
- 295.007R** Catastrophic Closure of Residency Programs and Institutions: That our AMA-RFS support working with: (1) other organizations with responsibilities for graduate medical education including the Accreditation Council on Graduate Medical Education (ACGME) and its constituent Residency Review Committees, the Association of American Medical Colleges (AAMC), the American Board of Medical Specialties (ABMS), the Council of Medical Specialty Societies (CMSS), and the Graduate Medical Education Advisory Committee (GMEAC) to develop policies to facilitate placement and completion of training for residents in good standing whose program or institution closes or downsizes; and (2) specialty societies and program director organizations to identify vacant and potential residency positions for placement of displaced residents. (Substitute Resolution 32, I-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 295.008R** Residency Program Responsibility for Resident Education: That our AMA-RFS: (1) direct its representative to the ACGME to affirm that residency programs are responsible for offering and supervising curriculum of education that will develop the requisite clinical skills and professional competencies for the residents to practice in their chosen specialties; (2) support that the basic skills and competencies for the practice of medicine and its specialties must be determined solely by the medical profession; and (3) supporting monitoring attempts by outside groups to legislate or regulate medical education curricula. (Substitute Resolution 31, I-95) [See also: AMA Policy H-165.932, H-295.995] (Reaffirmed Report D, I-16)
- 295.009R** Improving Patient Safety Through Collaboration in Resident and Fellow Education: That our AMA-RFS support partnering with stakeholder organizations including the

ACGME (Accreditation Council on Graduate Medical Education) and AOA (American Osteopathic Association) to encourage partnership in the development and revision of residency and fellowship accreditation standards in order to better align the education experience of allopathic and osteopathic residents and fellows with the overall goal of assuring patient safety. (Resolution 5, A-12) (Reaffirmed Report E, A-22)

295.010R Displaced Residents: That our AMA-RFS support the Accreditation Council for Graduate Medical Education (ACGME): (1) establishing guidelines for non-academic closure or downsizing of residency programs and adequate advance notification to residents wherein such guidelines could include providing residents with information, resource contacts, assistance to facilitate transfer to another accredited training program where they could complete their training, and financial assistance programs; and (2) considering waiving requirements for continuous years of training at one program and other restrictions that would otherwise significantly delay their normal tenure for completion of training in the event a resident has been subject to the closure or downsizing of his or her residency program. (Substitute Resolution 2, A-94) [See also: AMA Policy H-310.943] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

296.000R Residency Programs: Transfers

296.001R Evaluating Resident Transfers in and Out of Residency Programs: That our AMA-RFS study the issue of resident transfers between programs to better identify the scope of this issue. (Resolution 2, A-14)

296.002R Residency Transfers: That the AMA-RFS: (1) continue to actively promote the resident and fellow vacancy page; (2) organize the information, including links to specialty society websites, on the resident and fellow vacancy page in a user-friendly format; (3) initiate conversation to integrate the resident and fellow vacancies into FRIEDA, a resource well known to residents and fellows, to make the information more widely distributed and easily accessible; (4) include information about procedures and logistics of transferring residency and fellowship programs or specialties. (Report E, A-17)

300.000R MEDICAL RECORDS

300.001R Inclusion of Sexual Orientation and Gender Identity Information in Electronic Health Records: That our AMA-RFS advocate for inclusion of sexual orientation and gender identity in electronic health records (EHRs). (Resolution 2, A-16)

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]

- 300.003R** Protecting Patient Privacy Against Federal Judicial Intrusion: That our AMA-RFS oppose: (1) intrusions on the physician-patient relationship; and (2) any requests by outside bodies for confidential patient medical records without a valid legal justification or without appropriate patient authorization. (Substitute Resolution 6, A-04) (Reaffirmed Report D, I-14) [See also: AMA HOD Resolution 232, adopted, A-04]
- 300.004R** HHS Changes to Medical Privacy Regulation: That our AMA-RFS support the current efforts of the AMA in addressing the issue of privacy regulations. (Report H, I-02) (Reaffirmed Report D, I-16)
- 300.005R** Ownership and Sale of Medical Data: That our AMA-RFS support the AMA developing model legislation concerning ownership of medical records. (Resolution 9, A-18)
- 300.006R** Removing Sex Designation from the Public Portion of the Birth Certificate: That our AMA-RFS advocate for the removal of "sex" as a designation on the public portion of the birth certificate, and that it be visible for medical and statistical use only. (Resolution 10, I-19)
- 300.007R** Pharmaceutical Advertising in Electronic Health Record Systems: That our AMA-RFS oppose medical education institutions and teaching hospitals accepting pharmaceutical and device advertising in EHRs. (Report H, I-20)
- 310.000R** **MEDICAL REVIEW**
- 320.000R** **MEDICAL SOCIETIES**
- 320.001R** Resident Participation in Specialty Societies: That our AMA-RFS: (1) support national medical specialty societies fostering resident physician membership and participation in their policy formulation and leadership development; and (2) continue to encourage the development of resident physicians sections among national medical specialty societies. (Substitute Resolution 10, A-88) (Reaffirmed Report C, I-98) [See also: AMA Policy H-325.990] (Reaffirmed Report D, I-16)
- 320.002R** Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine: That our AMA-RFS support: 1) conducting studies on the participation of academic and teaching physicians, residents, fellows, and medical students, and community-based faculty members of medical schools and graduate medical education programs in organized medicine on medical school campuses and in teaching hospitals; 2) identifying successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine at the training sites. (Late Resolution 2, A-17)

330.000R MEDICARE

330.001R Practice Expense: That our AMA actively oppose and advocate against HCFA’s using the SMS as the sole source of data from which the specialty specific practice expenses per hour is calculated and that the AMA support HCFA’s utilizing data from specialty society sources where that data exists. (Emergency Resolution 2, A-98) (Reaffirmed Report D, I-16)

330.002R Payment for Federally Mandated Emergency Care: That our AMA-RFS support an equitable adjustment to the medical physician fee schedule to provide fair compensation to offset the additional professional and practice expenses required to comply with EMTALA. (Emergency Resolution 1, A-98) (Reaffirmed Report D, I-16)

330.003R Effective Communication with HCFA: That our AMA-RFS Governing Council meet with the Health Care Financing Administration (HCFA) to discuss the Medicare guidelines governing reimbursement for resident supervision during residency training with a report back the AMA-RFS Assembly. (Substitute Resolution 6, I-97) (Reaffirmed Report C, I-07)

340.000R PATIENT SAFETY

340.001R Universal Color Scheme for Respiratory Inhalers: That our AMA-RFS support: (1) working with leading respiratory inhaler manufacturing companies and health agencies such as the Federal Drug Administration (FDA) and the American Pharmacists Association (APhA) to develop consensus of a universal color scheme for short-acting beta-2 agonist respiratory inhalers that are used as “rescue inhalers” in the United States; (2) working with leading respiratory inhaler manufacturing companies to ensure a universal color scheme for respiratory inhalers would allow for the least disruption possible to current inhaler colors, taking into account distribution of each brand and impact on current users if color were to change; and (3) working with leading respiratory inhaler manufacturing companies to ensure that any universal color scheme for respiratory inhalers be designed for adherence and sustainability, including governance for future companies entering the respiratory inhaler market, and reserving colors for possible new drug classes in the future. (Resolution 14, A-16)

340.002R Cumulative Radiation Exposure: That our AMA-RFS support: (1) current FDA policy including safe use of medical imaging devices, informed clinical decision making, and increasing patient awareness; (2) working with all relevant parties to advocate for inclusion of an individual registry containing the patient’s historical (test and procedure-based) cumulative radiation dose, as well as research the fiscal impact such a registry would incur; (3) the continued development and use of standardized electronic medical record (EMR) systems that will help physicians track the number of imaging procedures a patient is receiving and that will help physicians discuss the potential dangers of high level of radiation exposure with patients; and (4) initiatives to increase awareness of ionizing radiation exposure from medical imaging and practices that lower radiation exposure from medical imaging,

such as the “Image Wisely” “Image Gently” Campaigns. (Resolution 10 and Report E, A-11)

- 340.003R** Patient Prescriptions: That our AMA-RFS support improving prescription labeling for visually or otherwise impaired patients and increasing awareness of available resources. (Late Resolution 1, A-08)
- 340.004R** Improving Transfer of Care Communication: That our AMA-RFS investigate models of effective, efficient transfer of care communication, taking into consideration the use of electronic medical records. (Resolution 10, A-07)
- 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 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)
- 340.006R** Encouraging Protocols to Assist with the Management of Obese Patients: That our AMA-RFS support healthcare providers learning about techniques and devices to prevent potential injury and to provide safe and efficient care for obese patients. (Resolution 6, I-14)
- 340.007R** Sustainable Community-Based Falls Prevention Programs to Optimize Functional Outcomes in Elderly Populations: That our AMA-RFS support working with relevant organizations to encourage research into community-based falls prevention programs. (Resolution 10, I-14)
- 340.008R** Education on, Screening, and Reporting of Elder Abuse and Neglect: That our AMA-RFS support promoting elder abuse screening during patient encounters when deemed appropriate by the provider. (Resolution 4, A-17)
- 340.009R** Delegation of Informed Consent: That our AMA-RFS support: (1) that a qualified physician be able to delegate his or her duty to obtain informed consent to another provider that has knowledge of the patient, the patient’s condition, and the procedures to be performed on the patient; and (2) studying the implications of the *Shinal v. Toms* ruling and its potential effects on the informed consent process. (Resolution 11, I-18)
- 340.010R** The Criminalization of Health Care Decision Making and Practice: That our AMA-RFS support the AMA in amending policy H-160.946, “The Criminalization of Health Care Decision Making” by addition and deletion with a change in title to read as follows: “The Criminalization of Health Care Decision Making and Practice H-160.946” ~~That our~~ The AMA: (1) opposes the attempted criminalization of health care decision-making, practice, malpractice, and medical errors, including medication errors related to electronic medical record or other system errors,

especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and (2) actively update and promote ~~will develop~~ model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making and practice, including cases involving allegations of medical malpractice and medical errors; and (3) implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making, practice, malpractice, and medical errors; and (2) That our AMA-RFS support the AMA in studying the increasing criminalization of health care decision-making, practice, malpractice, and medical errors with report back on our advocacy to oppose this trend; and (3) That our AMA-RFS support the AMA in studying the ramifications of trying all health care decision-making, practice, malpractice, and medical error cases in health courts instead of criminal courts; and that our AMA-RFS support the AMA in reaffirming policies H-120.921, H-160.954, H-375.984, H-375.997, and H-435.950. (Alternate Resolution 5, A-22)

350.000R MINORITIES

350.001R Opposition to Funding Cuts for HRSA Programs: That our AMA-RFS: (1) support working with other interested organizations to educate the public about the importance of the Health Careers Opportunity Program and the Centers of Excellence Program, which encourages underrepresented minorities to consider a career in medicine and helps to increase the supply of minority health professionals; and (2) oppose any proposed legislation to reduce or eliminate funding for the Health Careers Opportunity Program and the Centers of Excellence Program. (Resolution 6, I-06) [See also: CME Report 1 and Resolutions 828 and 830, I-06] (Reaffirmed Report D, I-16)

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 *Doctors Back to School Program* in order to attract more underrepresented minority students 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)

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

- 350.004R** Recognition of National Anti-Lynching Legislation as Public Health Initiative: That our AMA-RFS support the AMA in supporting national legislation that recognizes lynching and mob violence towards an individual or group of individuals as hate crimes; working with relevant stakeholders to support medical students, trainees, and physicians receiving education on the inter-generational health outcomes related to lynching and its impact on the health of vulnerable populations; and amending AMA Policy H-65.965 “Support of Human Rights and Freedom” to read: (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, phenotypic appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States; and reaffirming AMA policy H-65.952 “Racism as a Public Health Threat. (Resolution 10, I-21)
- 350.005R** Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic: That our AMA-RFS support the AMA in supporting training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; and supporting the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and reaffirming existing policies H-160.903, “Eradicating Homelessness,” and H-345.975, “Maintaining Mental Health Services by States,” and H-160.978, “The Mentally Ill Homeless”, with a title change to “Housing Insecure Individuals with Mental Illness.” (Alternate Resolution 11, I-21)
- 350.006R** Prohibition of Death Penalty for Persons with Serious Mental Illness: That our AMA-RFS support that defendants charged with capital crimes should not be sentenced to death or executed if, at the time of the offense, they had a mental disorder or disability that significantly impaired their capacity to appreciate the nature, consequences or wrongfulness of their conduct, to exercise rational judgment in relation to their conduct, or to conform their conduct to the requirements of the law. (Resolution 1, I-22)
- 350.007R** Increasing Minority and Underrepresented Group Participation in Clinical Research: That our AMA-RFS support our AMA in amending H-460.911, Increasing Minority Participation in Clinical Research, by addition and deletion to read as follows:
Increasing Minority and Underrepresented Group Participation in Clinical Research H-460.911
1. Our AMA advocates that:
a. The Food and Drug Administration (FDA) and National Institutes of Health (NIH) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.

- b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
 - c. Resources be provided to community level agencies that work with those minorities and underrepresented groups who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include African Americans, Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.
2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities and underrepresented groups in clinical trials:
- a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;
 - b. Increased outreach to ~~female~~ all physicians to encourage recruitment of ~~female~~ patients from underrepresented groups in clinical trials;
 - c. Continued ~~minority physician~~ education for all physicians and physicians-in-training on clinical trials, subject recruitment, subject safety, and possible expense reimbursements, and that this education encompass discussion of barriers that currently constrain appropriate recruitment of underrepresented groups and methods for increasing trial accessibility for patients;
 - d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
 - e. Fiscal support for minority and underrepresented group recruitment efforts and increasing trial accessibility through optimized patient-centered locations for accessing trials, the ready availability of transportation to and from trial locations, child care services, and transportation, child care, reimbursements, and location.
- (Alternate Resolution 2, I-22)

360.000R ORGAN DONATION AND TRANSPLANTATION

360.001R Removing Barriers to Organ Donation: That our AMA-RFS support the AMA working with legislators to remove financial barriers to living organ donation to pass laws which include: (1) provisions for expenses involved in the donation incurred by the organ donor, (2) providing access to health care coverage for any medical expense or disability related to the donation, (3) prohibiting employment discrimination on the basis of living donor status, and (4) prohibiting the use of living donor status as the sole basis for denying health and life insurance coverage. (Resolution 4, A-11)

360.002R National Marrow Donor Program: Cord Blood Donation: That our AMA-RFS support: (1) working with Health Resources and Service Administration to increase the availability and access for expectant mothers to donate their cord blood to the National Marrow Donor Program within every state; and (2) drafting and promoting model state and federal legislation to present the option to all expectant mothers of donating cord blood. (Substitute Resolution 12, I-01) (Reaffirmed Report D, I-16)

360.003R National Marrow Donor Program: That our AMA-RFS support requesting all blood donation organizations to make provisions within their standard operating procedures as filed with the FDA to allow, when appropriate and technically feasible, access to the IV blood collection system for registration of a volunteer with the National Marrow Donor Program. (Resolution 29, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

360.004R Support of Elimination of the Deferment Period for Blood Donation by Men Who Have Sex with Men (MSM): That our AMA-RFS support AMA Policies H-50.973, H-50.977, H-50.972, H-50.995, and H-50.998 be reaffirmed. (Resolution 2, A-23)

370.000R **PHYSICIAN PAYMENT**

370.001R Reimbursement for Phone Consultations: That our AMA-RFS support working with relevant parties to create a method of billing and reimbursement for phone consultations. (Report F, I-11)

370.002R Reimbursement Neutrality in the Merit-Based Incentive Payment System (MIPS) of MACRA: That our AMA-RFS: (1) limit support of initiatives included in the Merit-Based Incentive Payment System (MIPS) to those which are projected to be neutral with respect to geography and specialty; and (2) advocate for transparency among public and private payors in the creation and utilization of formulas intended to rank physicians for the purposes of reimbursement of public comparison. (Resolution 11, I-16)

370.003R Improving Utility of Clinical Documentation: That our AMA-RFS advocate that the appropriate institutions determine level of care and reimbursement based more on complexity of medical diagnoses and medical decision making rather than quantity of components in medical documentation. (Resolution 12, I-17)

370.004R Supporting the Reclassification of Complex Rehabilitation Technology to Improve Access to Individuals with Substantially Disabling and Chronic Conditions: That our AMA-RFS support reclassifying complex rehabilitation technology equipment into its own distinct payment category under the Centers for Medicare & Medicaid Services to improve access to individuals with substantially disabling and chronic conditions. (Resolution 4, A-19)

380.000R **PHYSICIANS AND NON-PHYSICIAN PROVIDERS**

380.001R Protecting the Privacy of Physician Information Held by the ACGME: That our AMA-RFS support: (1) requesting that the Accreditation Council for Graduate Medical Education (ACGME) and any other organization with a similar case and procedure log for resident physicians develop and implement a system to remove or sufficiently protect identifying data from individual physicians' data logs; (2) requesting that the ACGME and any other organization with a similar case and procedure log for resident physicians adopt a policy not to disseminate any data specific to individual physicians without the written consent of the physician; and (3) requesting that the ACGME and any other organization with a similar case and procedure log for resident physicians permanently expunge its database of specific

identifying physician information upon completion or cessation of training. (Late Resolution 1, I-03) [HOD Resolution 301, A-04] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

- 380.002R** Independent Practice of Medicine: That our AMA-RFS support: (1) working at the local, state, and federal levels of government, through both legislation and regulation, to prevent the independent practice of medicine by mid-level health care providers, as medicine should only be practiced by a fully licensed physician qualified by reason of education, training, and experience in such practice; and (2) working toward regulation and legislation that create reimbursement models do not reimburse mid-level providers at the same rates as physicians. (Resolution 8, A-11)
- 380.003R** Proper Identification of Health Care Providers: That our AMA-RFS support state medical boards and state medical societies in adopting advisory opinions and advancing legislation requiring all healthcare providers to clearly identify their credentials to patients. (Resolution 9, A-11)
- 380.004R** Scope of Practice of Mid-Level Providers: That our AMA-RFS oppose the independent practice of mid-level providers in the interest of patient safety and provider competency. (Resolution 3, A-10)
- 380.005R** Radiation Oncology is not an Ancillary Service: That our AMA 1) affirm that radiation therapy is not ancillary to any service; 2) that any designation of radiation therapy as an ancillary service is inaccurate; and 3) oppose any legal or other designation of Radiation therapy as an "in-office ancillary service." (Resolution 5, I-08)
- 380.007R** AMA Policy on Physician Provider Information: That our AMA investigate: (1) the publication of physician information on internet websites; and (2) potential solutions to erroneous physician information contained on Internet websites. (Substitute Resolution 13, A-07)
- 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]
- 380.009R** Part-Time Malpractice Insurance: That our AMA-RFS oppose reduced premiums for part-time physicians. (Substitute Resolution 4, I-01) (Reaffirmed Report D, I-16)

- 380.010R** Loan Payback in Shortage Areas: That our AMA utilize U.S. Senate Bill 288, House of Representatives Bill 324, and other legislative resources to achieve federal income tax exemption for state and federal loan repayment programs designed to improve physician supply in underserved areas. (Substitute Resolution 8, A-99) (Reaffirmed Report C, I-09)
- 380.011R** The Disruptive Physician: That our AMA-RFS support: (1) identifying and studying behavior by physicians that is disruptive to high quality patient care; and (2) defining the term “disruptive physician” and disseminating guidelines for managing the disruptive physician. (Report H, I-98) (Reaffirmed Report D, I-16)
- 380.012R** On-Call Physicians: That our AMA-RFS support working with the Federation, the American Hospital Association, the American College of Emergency Physicians, and other interested state medical and specialty societies to study trends in reimbursement, responsibilities and availability of on-call physicians and the impact of these trends on the timely delivery of emergency services. (Late Resolution 1, I-98) (Reaffirmed Report D, I-16)
- 380.013R** Physician Diversity: That our AMA-RFS support AMA policies 350.988, 350.991, 350.993, and 350.995 which encourage increased representation by minorities in medicine. (Substitute Resolution 7, A-98) (Reaffirmed Report D, I-16)
- 380.014R** “No Compete” Clauses in Residency and Fellowship Contracts: That our AMA-RFS strongly oppose contractual restrictions on the future practice of residents by institutions sponsoring residency training. (Substitute Resolution 5, A-97) (Reaffirmed Report C, I-07)
- 380.015R** Failure to Use and Implementation of Advance Directives: That our AMA-RFS support studying: (1) how to better educate physicians in the skills necessary to increase the prevalence of meaningful advance directives; and (2) how to improve recognition of, and adherence to, advance directives by health care facilities and staff. (Substitute Resolution 7, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 380.016R** Transition to Practice Information: That our AMA-RFS Governing Council review the availability of educational tools regarding transition to practice and provide information on how to obtain these tools. (Substitute Resolution 2, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 380.017R** "No Compete" Contracts: That our AMA-RFS support: (1) studying the development of model state legislation to effect changes in contract law that will preclude "no compete" clauses; and (2) making a formal statement against "no compete" contracts which border on antitrust activity. (Resolution 5, I-95) [See also: AMA Policy H-165.945] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 380.018R** Encouraging Academic Career and Adequate Research Funding: That our AMA-RFS support residents and young physicians of all disciplines considering careers in academic medicine. (Substitute Resolution 35, A-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

- 380.019R** Fees for NBME Scores: That our AMA-RFS direct its representatives to the NBME to use all available and appropriate means to effect a reduction in the fee for reporting scores by the NBME. (Resolution 15, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)
- 380.020R** Preserving Physician Leadership in Patient Care: That our AMA-RFS support the AMA in working with relevant stakeholders to commission an independent study comparing medical care provided by physician-led health care teams versus care provided by unsupervised non-physician providers, reporting on quality of health outcomes, cost and cost effectiveness, and access to necessary medical care, and publish the findings in a peer-reviewed medical journal. (Resolution 5, I-21)
- 380.021R** Preserving Physician Leadership in Patient Care: That our AMA-RFS support the AMA in creating a national targeted ad campaign to educate the public about the training pathway of physicians compared to non-physician providers; in reaffirming our opposition to physician being referred to as “providers” in healthcare settings; and conducting a review of the AMA policy compendium and replace conflicting policies referring to physicians as “providers” with the term “physician” when appropriate with report back at A-23. (Report B, A-22)
- 380.022R** Amend Policy D-275.948, “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”: That our AMA-RFS support our AMA in amending policy D-275.948 by addition and deletion to read as follows:
- 1.) Our AMA acknowledges that a conflict of interest exists when non-physician health care professionals hold positions on physician regulatory bodies or physician boards when these individuals represent a field that either possesses or seeks to possess the ability to practice without physician supervision; and
 - 2.) Our AMA will work with and advocate to key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (1) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected; and (2) review and amend their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision; and
 - 3.) Our AMA opposes any non-physician having a voting position on a regulatory body or physician board responsible for physician education, accreditation, certification, licensing, or credentialing; and be it further
 - ~~3.) Our AMA opposes any non-physician, with positions on regulatory bodies and physician boards involved with physician education, accreditation, certification, licensing, and credentialing, from holding a position with voting power on these bodies/boards and believes non-physicians should only hold non-voting roles which seek to provide a public voice; and be it further~~
 - ~~4.) Our AMA opposes any non-physician, with positions on regulatory bodies and physician boards involved with physician education, accreditation, certification, licensing, and credentialing, from holding a position on the executive committee on these bodies/boards as it conflicts with our “stop the scope creep campaign” and~~

~~undermines physician confidence in these organizations.; and be it further~~
(Resolution 3, A-23)

390.000R PREGNANCY (SEE ALSO: CHILDREN AND YOUTH)

390.001R Teenage Pregnancy Prevention: That our AMA-RFS support the AMA: (1) providing testimony to Congress; and (2) actively supporting funding that provides reproductive preventative screenings and family planning services which are an essential part of women's health services and vital for unintended pregnancy prevention. (Resolution 7, A-11)

390.002R Home Deliveries: That our AMA-RFS support the recent American College of Obstetricians and Gynecologists (ACOG) statement that "the safest setting for labor, delivery, and the immediate post-partum period is in the hospital, or a birthing center within a hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics (AAP) and ACOG, or in a freestanding birthing center that meets the standards of the Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American Association of Birth Centers." (Resolution 6, A-08)

390.003R Appropriate Conditions for Breastfeeding by Residents and Fellows: That our AMA-RFS encourage all medical schools and Graduate Medical Education programs to support all residents and medical students who provide breast milk for their infants, by providing appropriate time and facilities to express and store breast milk during the working day. (Late Resolution 3, A-05) (Reaffirmed Report E, A-16)

390.004R Guidelines on the Protection of Pregnant Health Care Workers and Their Fetuses From Exposure to Potential Infectious/Teratogenic Agents: That our AMA-RFS support the development of scientifically based safety guidelines to protect pregnant workers and their fetuses from hazardous exposure to infectious/teratogenic agents in the healthcare workplace. (Substitute Resolution 15, I-98) (Reaffirmed Report D, I-16)

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

needs. (Substitute Resolution 35, A-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10) [See also: AMA Policy H-420.969]

- 390.006R** Opposition to Criminalization of Reproductive Decision Making: That our AMA-RFS oppose any legislation or ballot measures that could criminalize in-vitro fertilization, contraception, or the management of ectopic and molar pregnancies. (Resolution 3, A-12) (Reaffirmed Report E, A-22)
- 390.007R** Oncofertility and Fertility Preservation Treatment: That our AMA-RFS: (1) support coverage for standard fertility preservation therapy by all payers when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician; and (2) advocate for appropriate legislation requiring coverage for fertility preservation therapy services when iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as determined by a licensed physician. (Resolution 6, A-12) (Reaffirmed Report E, A-22)
- 390.008R** Fair Access to Evidence-Based Family Planning Methods: That our AMA-RFS: (1) recognize that choices regarding family planning and medical or surgical termination of pregnancy are personal and autonomous and are to be made by a patient in concert with their health care provider; and (2) support changes to public and private payment mechanisms that would make evidence-based family planning methods and medical or surgical termination of pregnancy accessible to all patients, regardless of socioeconomic background. (Resolution 7, I-16)
- 390.009R** Protection of Access and Coverage of Women’s Preventative and Maternity Care: That our AMA-RFS support legislation and regulations that ensures women have comprehensive coverage and access to preventative care, contraception, and maternity care with no cost sharing. (Late Resolution 1, A-17) (Reaffirmed Resolution 16, I-17)
- 390.010R** Removal of the Food and Drug Administration Risk Evaluation and Mitigation Strategy for Mifepristone Use in Early Pregnancy Failure: That our AMA-RFS support: (1) the removal of the FDA Risk Evaluation and Mitigation Strategy for mifepristone in early pregnancy failure; and (2) education and training of practitioners who diagnose and are allowed to treat early pregnancy failure with mifepristone. (Resolution 5, A-18)
- 390.011R** Extending Pregnancy Medicaid To One Year Postpartum: That our AMA-RFS support CMS extending pregnancy Medicaid to a minimum of one year postpartum. (Late Resolution 1, I-18)
- 390.012R** Support for Medicare Disability Coverage of Contraception for Non- Contraceptive Use: That our AMA-RFS support working with Center for Medicare and Medicaid Services and other stakeholders to include coverage for all FDA-approved contraception, for non-contraceptive use for patients covered by Medicare. (Resolution 1, I-18)

- 390.013R** Support for Medicare Disability Coverage of Contraception for Women of Reproductive Age: That our AMA-RFS support CMS providing coverage for all FDA-approved contraception for reproductive aged women covered by Medicare disability insurance.
- 390.014R** Contraception for Incarcerated Women: That our AMA-RFS support incarcerated persons' access to evidence-based contraception counseling, access to all contraceptive methods and autonomy over contraceptive decision making prior to release. (Resolution 6, I-18)
- 390.015R** Contraceptive Access: That our AMA-RFS support: (1) the continued use of public funding for affordable and accessible family planning services that are free of undue burden, in an effort to reduce the rates of unplanned pregnancies; (2) over-the-counter access to contraceptives; (3) policies and any work the AMA does with other interested organizations to increase access to and awareness of over-the-counter emergency contraception; (4) affordable Long-Acting Reversible Contraception access for all patients, including those in the immediate postpartum period; and (5) training and financial assistance for providers to offer Long-Acting Reversible Contraception. (Report C, A-19)

400.000R **PROFESSIONAL LIABILITY**

- 400.001R** Criminalization of Providing Healthcare to Undocumented Residents: That our AMA: (1) reaffirm AMA Policy H-440.876; (2) work with local and state medical societies to immediately, actively and publicly oppose any legislative proposals that would criminalize the provision of healthcare to undocumented residents; and (3) oppose proof of citizenship as a condition of providing healthcare. (Resolution 6, A-07)
- 400.002R** Opposition of Central Data Collections of Physicians (in Particular Residents) Named in Malpractice Suits: That our AMA implement AMA Policy H-355.983 which opposes the reporting to the National Practitioner Data Bank of residents named in any malpractice suits which occurred during the required activities of residency training. (Substitute Resolution 13, A-97) (Reaffirmed Report C, I-07)
- 400.002R** Primary Care Physician Liability Under Managed Care Contracts: That our AMA-RFS support strategies to minimize liability exposure of primary care physicians who are restricted in their treatment and referral decisions by the managed care plan in which they are participating. (Substitute Resolution 12, A-96) (Reaffirmed Report C, I-06)
- 400.003R** Informing Residents about the National Practitioner Data Bank: That our AMA-RFS support the dissemination of information regarding the National Practitioner Data Bank. (Substitute Resolution 17, I-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)

410.000R **PUBLIC HEALTH**

- 410.001R** Addressing Decreased Access to Mammography: That our AMA-RFS support accessibility to screening mammography and oppose the inappropriate application use of the U.S. Preventative Services Task Force (USPSTF) mammography recommendations to limit access to reimbursement for screening with mammography when a patient and physician believe this to be a beneficial test for the patient. (Resolution 4, A-10)
- 410.002R** Direct to Consumer Advertising: That our AMA-RFS oppose Direct to Consumer Advertising of prescription drugs and implantable medical devices. (Report I, A-09) (Reaffirmed in lieu of adopting Resolution 8, A-16)
- 410.003R** Payment for Vaccines by Medicare: That our AMA lobby for Medicare to pay for both the cost of the vaccine and the cost of administration by physicians of all vaccines covered under Medicare Part D. (Late Resolution 2, A-08)
- 410.004R** Safe Disposal of Unused Pharmaceuticals: That our AMA-RFS support: (1) requesting that the Environmental Protection Agency conduct studies to better understand the public health and environmental impact of discarded pharmaceuticals on the nation's drinking water; and (2) developing programmatic guidelines for the disposal of unused pharmaceuticals that optimally protect public health, patient confidentiality, and environmental resources. (Resolution 1, I-05) [See also: AMA Policy H-135.993] (Reaffirmed Report E, A-16)
- 410.005R** Covering the Uninsured as AMA's Top Priority: That the AMA-RFS support health system reform that achieves reasonable health insurance for all Americans which emphasizes prevention, quality and safety in such a way that addresses the broken medical liability system and the flaws in Medicare and Medicaid and improves the physician practice environment. (Report I, I-05) [See also: AMA Policy H-165.847] (Reaffirmed Report E, A-16)
- 410.006R** Obesity Epidemic: That the AMA-RFS: (1) recognize obesity as a health problem of epidemic proportions; and (2) recognize that education regarding identification and prevention of obesity is appropriate. (Resolution 5, A-04) (Reaffirmed Report D, I-14)
- 410.007R** Tuberculosis Screening for Temporary Nonimmigrants: That the AMA-RFS support the efforts of the AMA Council on Scientific Affairs in addressing the issue of tuberculosis screening for non-immigrant visitors. (Report E, I-02) (Reaffirmed Report D, I-16)
- 410.008R** Exercise and Healthy Eating for Children: That our AMA-RFS: (1) support legislation that would require the development and implementation of universal nutrition standards for all food served in K-12 schools irrespective of food vendor or provider; and (2) spearhead a public health awareness campaign and enhance the K-12 curriculum to address and educate the public on the epidemic of childhood obesity and the benefits of exercise and physical fitness for children. (Substitute Resolution 6, A-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)

- 410.009R** Addressing Antibiotic Resistance: That our RFS support the recommendations in AMA Council on Scientific Affairs Report 3 (A-00), Combating Antibiotic resistance Via Physician Action and Education: AMA Activities. (Substitute Resolution 10, A-01) (Reaffirmed Report D, I-16)
- 410.010R** Mercury Exposure and the Reduction of Fish Consumption: That our AMA-RFS support the FDA's efforts to educate consumers about mercury exposure from fish consumption. (Substitute Resolution 5, A-01) (Reaffirmed Report D, I-16)
- 410.011R** Impact of Biodiversity Loss on Human Health: That our AMA-RFS support legislation that protects biodiversity for the purpose of benefiting human health, especially in terms of the development of drugs and biologicals to treat diseases. (Substitute Resolution 4, A-01) (Reaffirmed Report D, I-16)
- 410.012R** Use of Bittering Agents as a Deterrent Against Ingestion of Potentially Toxic Household Products: That our AMA-RFS support any AMA efforts to encourage the use of bittering agents in household and other products which represent potential toxic hazards when ingested. (Substitute Resolution 19, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09)
- 410.013R** Low Literacy as a Barrier to Healthcare: That: (1) our AMA-RFS support the recommendations outlined in the Council on Scientific Affairs Report 1 (A-98); and (2) our AMA develop and implement initiatives to raise awareness among residents and fellows, of limited patient literacy. (Substitute Resolution 4, A-99) (Reaffirmed Report C, I-09)
- 410.014R** National Standardization of Pre-participation Screening and Examination of High School Athletes: That our AMA-RFS support dissemination of current American Heart Association guidelines regarding pre-participation screening and examination of high school athletes. (Substitute Resolution 16, I-98) (Reaffirmed Report D, I-16)
- 410.015R** Chlamydia Trachomatis as a Reportable Disease: That our AMA-RFS support state health departments following up on patients testing positive for Chlamydia Trachomatis by notifying the patients and their potential contacts of methods to reduce or avoid their chances of infection, reinfection, or progression of the disease. (Substitute Resolution 15, A-98) [See also: AMA Policy H-440.900] (Reaffirmed Report D, I-16)
- 410.016R** Increasing Antibiotic Resident Bacteria Awareness: That our AMA-RFS support the appropriate healthcare agencies in increasing public education about the judicious use of antibiotics and the dangers of antibiotic resistant pathogens. (Substitute Resolution 14, A-98) [See also: AMA Policy H-100.973] (Reaffirmed Report D, I-16)
- 410.017R** Public Health Care Benefits: That our AMA-RFS support maintenance of funding for public health care benefits for all immigrants. (Substitute Resolution 2, I-97) (Reaffirmed Report C, I-07) [See also: AMA Policy H-440.903]

- 410.018R** Danger of Car Phones: That our AMA support further study into the dangers of the use of car phones and their impact on road traffic safety. (Substitute Resolution 20, A-97) (Reaffirmed Report C, I-07)
- 410.019R** Latex Alternatives: That our AMA-RFS strongly encourage health care facilities to provide non-latex alternatives alongside their latex counterparts in all areas of patient care. (Substitute Resolution 3, A-97) (Reaffirmed Report C, I-07)
- 410.020R** Protection of Ocular Injuries From BB and Air Guns: That our AMA-RFS support businesses that sell BB and air guns making polycarbonate protective eye wear available to their customers and distributing educational materials on the safe use of non-powder guns. (Substitute Resolution 23, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 410.021R** Latex Allergy Warning: That our AMA-RFS support labeling on medical products specifying “contains latex,” when applicable. (Substitute Resolution 6, A-96) (Reaffirmed Report C, I-06)
- 410.022R** Bittering Agents to Reduce Accidental Poisonings: That our AMA-RFS support any legislation or regulations mandating the use of bittering agents in household products to reduce accidental poisonings. (Resolution 8, A-95) [See also: AMA Policy H-10.976] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 410.023R** Skin Cancer Surveillance through Hairdresser and Barber Education: That our AMA-RFS support: (1) the American Academy of Dermatology developing studies to further examine the potential role of hair professionals in skin cancer identification; and (2) encouraging the American Academy of Dermatology to investigate mechanisms for referral of identified individuals to qualified health care providers. (Resolution 1, A-12) (Reaffirmed Report E, A-22)
- 410.024R** The Health Costs of Hydraulic Fracturing: That our AMA-RFS support: (1) the idea of disease registries for long-term monitoring and mitigation of health effects potentially related to hydraulic fracturing; and (2) studying the potential health risks and impacts of hydraulic fracturing and the estimated health costs to states, insurers, employers, and the health care system. (Resolution 2, A-12) (Reaffirmed Report E, A-22)
- 410.025R** Environmental Toxins and Reproductive Health: That our AMA-RFS support: (1) rigorous scientific investigation into the causes and prevention of birth defects; (2) rigorous scientific investigation into the linkages between environmental hazards and adverse reproductive and developmental health outcomes; (3) policies to identify and reduce exposure to environmental toxic agents; (4) policies to address the consequences of exposure to environmental toxic agents including the reporting of identified environmental hazards to appropriate agencies; (5) physicians learning about toxic environmental agents common in their community and educating patients on how to avoid toxic environmental agents; and (6) policies and practices that promote a healthy food system. (Resolution 3, A-14)

- 410.026R** Insurance Coverage for Fertility Preservations in Patients Receiving Cytotoxic or Immunomodulatory Agents: That our AMA-RFS support: (1) payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or by necessary cytotoxic and/or immunomodulatory therapies as determined by a licensed physician; and (2) lobbying for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary cytotoxic and/or immunomodulatory therapies as determined by a licensed physician. (Resolution 5, A-14)
- 410.027R** AMA Response to Epidemics and Pandemics: That our AMA-RFS supports the AMA: (1) providing regular updates in a timely manner on any disease classified by the World Health Organization as urgent epidemics or pandemics potentially affecting the US population; (2) working with the CDC and international health organizations to provide organizational assistance to curb epidemics and pandemics, including calling on American physicians to provide needed resources such as human capital and patient care related supplies; and (3) encouraging relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics. (Resolution 5, I-14) [HOD Resolution 925, I-14]
- 410.028R** Addressing Immigrant Health Disparities: That our AMA-RFS support: (1) urging federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children regardless of legal status, based on medical evidence and disease epidemiology; (2) advocating against and publicly correcting medically inaccurate accusations that contribute to anxiety, fear, and marginalization of specific populations; and (3) advocating for policies to make available and effectively deploy resources needed to narrow health disparities borne by immigrants, refugees, or asylees. (Resolution 9, I-14)
- 410.029R** Medical Vaccination Exemptions: That our AMA-RFS support: (1) the removal of all state-based, non-medical exemptions to vaccination in accordance with each state's list of required vaccinations; and (2) legislative efforts that would establish national vaccination requirements for minors. (Resolution 18, A-15)
- 410.030R** Emergent Communicable Disease Public Health Crises: That our AMA-RFS support AMA efforts in urging Congress to expeditiously act to ensure sufficient funding for research, prevention, diagnosis, control, and treatment of newly identified communicable diseases that pose a public health emergency without diverting resources from other essential health initiatives. (Resolution 6, I-16; Amended Resolution 2, A-17)
- 410.031R** Regulating Tattoo and Permanent Makeup Inks: That our AMA-RFS support: (1) the Food and Drug Administration (FDA) adopting regulatory standards for tattoo and permanent makeup inks that include at minimum the disclosures expected for injectable drugs and cosmetics and mandate that this information be available to both the body licensed to perform the tattoo and to the person receiving the tattoo; and (2) studying the safety of any chemical in tattoo and permanent makeup inks. (Resolution 1, I-17)

410.032R Coordinating Correctional and Community Healthcare: That our AMA-RFS support: (1) linkage of those incarcerated to community clinics upon release in order to accelerate access to primary care and improve health outcomes among this vulnerable patient population as well as adequate funding; and (2) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community. (Resolution 10, A-18)

410.033R Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time: That our AMA-RFS support our AMA in the elimination of seasonal time changes and the adoption of year-round standard time. (Resolution 6, A-22)

410.034R Decriminalizing and Destigmatizing Perinatal Substance Use Treatment: That our AMA-RFS support our AMA in advocating that prenatal and peripartum toxicology tests should not be obtained without the informed consent of the birthing parent, if they have capacity to provide consent; and that our AMA-RFS support that state and federal child protection laws should be amended so that reporting of pregnant people with substance use disorders are only reported to welfare agencies when protective concerns are identified by the clinical team, rather than through mandated or categorical referral of all pregnant people with a positive toxicology test or verbal substance use screen. (Resolution 7, A-23)

410.035R Traffic-related Death as a Public Health Crisis: That our AMA-RFS support our AMA in reaffirming HOD Policy H-15.990, “Automobile Related Injuries.” (Resolution 9, A-23)

420.000R **RESEARCH**

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 independent access to source study data from clinical drug, biologic, and device trials. (Report G, I-13) [HOD Resolution 503, A-14]

420.002R Protecting Publisher’s Copyright on Scientific Material: That our AMA-RFS support studying: (1) the potential impact of the published model espoused in the NIH notice “Enhanced Public Access to NIH Research Information”; and (2) the impact of the author-paid model on the quality of scientific publication and the peer-review process. (Substitute Resolution 3, I-04) (Reaffirmed Report D, I-14)

420.003R The Study of the Federation: That our AMA-RFS support the goals of the Study of the Federation in order to strengthen patient advocacy, quality of care, and the profession of medicine. (Resolution 34, A-96) (Reaffirmed Report D, I-16)

420.004R Continued Support for the Agency for Health Care Policy and Research (AHCPR): That our AMA-RFS ask the AMA to call on Congress and the President of the United States to support the AHCPR at stable or increased levels of funding, taking into account the additional financial burden imposed by the National Medical

Expenditures Survey which is conducted at regular intervals. (Substitute Resolution 21, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

- 420.005R** Alternative vs. Adjunctive Medical Treatments: That our AMA-RFS support the scientific investigation of alternative medicine techniques. (Substitute Resolution 10, I-95) [See also: AMA Policy H-185.996] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)
- 420.006R** Comprehensive Access to Safety Data from Clinical Trials: That our AMA-RFS support: (1) the FDA investigating and developing means by which academic investigators can access original source safety data from industry-sponsored trials upon request; and (2) support the adoption of universal policy by medical journals requiring principal investigators to have independent access to all study data from industry-sponsored trials.
- 420.007R** Overemphasis on P-Values in Medical Literature: That our AMA-RFS: (1) oppose the use of generalized qualitative statements of significance, such as through the use of p-values, without the reporting of effect-size, such as through the use of confidence intervals; (2) support the formation of a clear distinction between statistical significance and clinical significance in the planning and reporting stages of scientific research; (3) support, through formal communication to major medical journals and publications, efforts to improve scientific integrity in medical literature by: (i) discouraging the reporting of hypothesis testing with generalized phrases such as “significant” or “p-value < 0.05;” (ii) promoting the reporting of effect size and measures of spread or variability, such as confidence intervals and standard deviations; (iii) requiring that authors clearly distinguish between accepted levels of statistical significance and clinical significance; and (iv) making efforts to anticipate and avoid language that may mislead as to the importance or impact of a statistical outcome when communicating the results of medical studies to the general public; and (4) support efforts to incorporate ongoing education on statistical interpretation and reporting in undergraduate, graduate, and continuing medical education with an emphasis on interpreting the distinction between clinical and statistical significance. (Resolution 8, A-14)
- 420.008R** Principles of Human Subjects Research Shall Apply to Online Research Projects: That our AMA-RFS: (1) considers social media sites’ Terms of Service as an insufficient proxy for informed consent prior to being enrolled in an experiment; and (2) supports online social networks providing users with specific informed consent outlining the aims, risks, and possible benefits of an experiment prior to study enrollment. (Resolution 1, I-14)
- 420.009R** Prevention of Physician and Medical Student Suicide: That our AMA-RFS support the Liaison Committee on Medical Education and Accreditation Council of Graduate Medical Education collecting data on medical student, resident and fellow suicides to identify patterns that could predict such events. (Resolution 2, I-17)

430.000R **TECHNOLOGY – COMPUTER**

440.000R TECHNOLOGY - MEDICAL

- 440.001R** Privacy Personal Use and Funding of Mobile Devices: That our AMA-RFS ask that our AMA: (1) encourage further research in integrating mobile devices in clinical care, particularly to address challenges of reducing work burden while maintain clinical autonomy for residents and fellows; (2) collaborate with the ACGME to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure a more uniformed regulation of mobile devices in medical education and clinical training; and (3) encourage medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines in using personal devices in clinical environment. (Report F, A-16)
- 440.002R** Interoperability of Medical Devices: That our AMA adopt the following statement on the Interoperability of Medical Devices: “The AMA believes that intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. The AMA also recognizes that, as in all technological advances, interoperability poses safety and medico legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve maximum patient safety, efficiency, and outcome benefit.” (Resolution 1, I-08)
- 440.003R** Genetic Screening: That our AMA-RFS: (1) support legislative action providing for the confidentiality of information obtained from genetic tests, such that it cannot be used: a) in making decisions concerning employment, b) by insurance companies in making decisions about eligibility for health insurance, and c) by insurance companies in making decisions about eligibility for group life and disability insurance; and (2) support all genetic diagnostic services being held to carefully considered and practicable standards; such that, at a minimum, proposed genetic screening plans should demonstrate: a) well-defined and attainable goals, b) provisions for patient education and counseling, c) informed consent, d) an accurate and reliable test, e) a mechanism for quality control, f) acceptable costs, g) assurance of equal access, and h) adequate follow-up services. (Substitute Resolution 19, A-94) [AMA Res. 503, I-94 was referred] (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 440.004R** Familiarity and Utilization of Mobile Medical Technology: That our AMA-RFS: (1) support the development of educational programming on how to use mobile medical applications for clinical decision-making support, for communication with patients, and how to advise patients to best use mobile technology for health benefit; (2) encourage our AMA to work with other interested stakeholders such as the innovators of existing mobile applications and other medical societies to develop or improve existing mobile applications to deliver accurate medical information based on current medical guidelines; and (3) encourage our AMA to educate physicians on discerning between evidence-based mobile applications and mobile applications that are not medically accurate. (Resolution 14, A-14)

440.005R Support for the Development and Distribution of HIPAA-compliant Communication Technologies: That our AMA-RFS support the development and use of HIPAA-compliant technologies for text messaging, electronic mail and video conferencing. (Resolution 15, I-17)

440.006R Decreasing the Use of Oximetry Monitors for the Prevention of Sudden Infant Death Syndrome: That our AMA-RFS oppose the sale and use of monitors to prevent sudden infant death syndrome. (Resolution 2, A-19)

450.000R **TELEVISION**

450.001R Television Rating System: That our AMA-RFS support the continued involvement of physicians and educators in the development of a television rating system that is practical, developmentally appropriate, and based on existing research and scientific knowledge. (Substitute Resolution 1, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

460.000R **TOBACCO**

460.001R Tobacco Regulation: That our AMA-RFS support the regulation of tobacco as a drug by the FDA. (Substitute Resolution 21, I-95) [See also: AMA Policy H-490.941, H-490.962] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

460.002R Tobacco Health Education and Advertising: That our AMA-RFS support programs of anti-tobacco health promotion and advertising. (Substitute Resolution 8, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09) [See also: AMA Policy H-490.959]

460.003R Smoke Free Residential Housing: That our AMA-RFS shall encourage health care institutions that provide employee housing to make such housing smoke free to the extent allowed applicable by local laws. (Resolution 2, A-15)

470.000R **TOBACCO: PROHIBITIONS ON SALE AND USE**

470.001R Restrictions on Adolescent Tobacco Sale: That our AMA-RFS oppose the sale of tobacco and nicotine products to minors. (Substitute Resolution 23, A-97) (Reaffirmed Report C, I-07)

470.002R Eliminating Financial Support for Politicians Who Receive Financial Support from the Tobacco Industry: That our AMA-RFS support: (1) AMPAC scrutinizing any politician's acceptance of funding from the tobacco industry when making decisions concerning the financial support of specific candidates; and (2) state and specialty medical society PAC's scrutinizing ant politician's acceptance of funding from the tobacco industry when making decisions concerning the financial support of specific candidates. (Substitute Resolution 19, A-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)

470.003R Duty-Free Allowances for Tobacco Products: That our AMA-RFS support the repeal of duty-free allowance for importing tobacco products into the United States. (Resolution 6, A-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

470.004R Smoking in Health Care Facilities: That our AMA-RFS oppose the use of all tobacco products everywhere on the premises of hospitals, physicians' offices and other health care facilities. (Resolution 7, A-85) (Reaffirmed Report C, A-95) [See also: AMA Policies H-505.991 and H-490.982.(4)] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

470.005R Regulation of Electronic Nicotine Delivery Systems (ENDS): That our AMA-RFS support: (1) taxing, labelling and regulating electronic nicotine delivery systems (ENDS) as tobacco products and drug delivery devices; (2) legislation that restricts the minimum age, locations of permissible use, advertising, promotion, and sponsorship of ENDS to that of tobacco products; (3) transparency and disclosure concerning design, content and emissions of ENDS; (4) secure, child-proof, tamper-proof packaging and design of ENDS; (5) enhanced labelling that warns of the potential consequences of ENDS use, restriction of ENDS marketing as tobacco cessation tools until clear evidence-based research arises suggesting the contrary, as well as restriction of the use of characterizing flavors in ENDS; and (6) basic, clinical, and epidemiological research concerning ENDS. (Resolution 15, A-14)

470.006R Taxation of Tobacco Products: That our AMA-RFS support legislation that taxes non-prescribed electronic nicotine delivery systems (ENDS) similarly to other tobacco products. (Resolution 12, A-15)

480.000R VIOLENCE AND ABUSE

480.001R Opposition to Violent and Sexually Explicit Television Programming: That our AMA-RFS support: (1) the AMA's continuing efforts to work with state and federal agencies as well as private organizations to retard the development of violent and sexually explicit programming; and (2) the AMA's continuing efforts to educate the public about the epidemiological risks of violent and sexually explicit television programming. (Substitute Resolution 15, I-95) [See also: AMA Policy H-485.995, H-485.994] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

490.000R WOMEN

490.001R Investigating the Continued Gender Disparities in Physician Salaries: That our AMA-RFS: (1) support eliminating gender disparities in physician salaries and professional development (e.g. promotions, tenure); and (2) oppose the causes of gender disparities in physician salaries and professional development. (Resolution 5, A-06) (Reaffirmed Report D, I-16)

500.000R AMA: ADMINISTRATION AND ORGANIZATION

500.001R AMA Physician Profile: (1) That our AMA ensure that the AMA Physician Profile and AMA Masterfile include the complete name of the training program (i.e. "Program Name" as listed on the Accreditation Council for Graduate Medical

Education (ACGME) website); (2) That our AMA ensure that the AMA Physician Profile and AMA Masterfile stop deleting from Physician Profiles and the Masterfile the name of the medical school or training program that is already listed and verified in the Physician Profile as it corresponds to the name of the institution at the time of the physician's graduation, and (3) That if the AMA Physician Profile and AMA Masterfile include the new updated name of a medical school or training program, this information be included in addition to but not in place of the name of the medical school or training program at the time of the physician's graduation. (Late Resolution 3, A-08)

- 500.002R** AMA Physician Profile for Residents Transferring Programs: That our AMA Physician Profile standard primary source verification confirming residency graduation states on the profile: "Completed Training: Program reports specialty training at this institution as Completed" for the program(s) from which a resident has graduated. (Late Resolution 4, A-08)
- 500.003R** Wheelchair Accessible Locations for All AMA Meetings: That our AMA-RFS support holding all meetings in locations that are wheelchair accessible. (Resolution 6, I-96) (Reaffirmed Report C, I-06) (Reaffirmed Report D, I-16)
- 500.004R** AMA Annual Meeting Schedule: That our AMA-RFS advocate for the AMA to change its House of Delegates Annual Meetings so that they take place prior to the last two weeks of June. (Resolution 16, A-91) (Reaffirmed Report C, I-01) (Reaffirmed Report D, I-16)
- 500.005R** Minimizing Unnecessary Mail: That our AMA: (1) offer to members on applications and renewals for membership the ability to refuse any AMA periodicals they do not wish to receive as member benefits; (2) offer to members on applications and renewals for membership the ability to exclude their names from mailing lists that the AMA may provide to outside vendors or publishers; and (3) encourage state, county, and medical specialty societies to establish similar mechanisms and policies. (Substitute Resolution 31, A-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)
- 500.006R** Waste Reduction and Fiscal Responsibility: That our AMA-RFS support the AMA reducing wastage whenever possible through reduction or elimination of the distribution of expendable supplies, such as notebook binders and stationery, to members of the Board, Councils, and Committees. (Resolution 46, A-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10) [See also: AMA Policy H-530.984]
- 500.007R** Discounted Registration Fees for AMA and Federation Seminars: That our AMA (1) adjust all of its registration fees to encourage and permit participation by resident physician and medical student members; and (2) urge all federation associations to discount their registration fees for seminars to accommodate their resident physician and medical student membership. (Resolution 10, I-89) (Reaffirmed Report C, I-99) (Reaffirmed Report C, I-09) [See also: AMA Policy H-530.986]

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)

510.000R **AMA: COUNCILS AND COMMITTEES**

510.001R Resident Representation on the American Medical Political Action Committee Board of Trustees: That our AMA-RFS support the appointment of a resident member to the AMPAC Board of Directors. (Substitute Resolution 28, A-96) (Reaffirmed Report C, I-06)

510.002R Campaign Expenditures for Resident Physician Candidates for AMA Offices: That the AMA-RFS support the following guidelines be followed by AMA-RFS-endorsed candidates: (1) Printed material should be factually accurate, tastefully reproduced and may include a limited number of mailings to the AMA House; (2) Candidates are encouraged to keep campaign paraphernalia to a minimum; (3) "Give away" items are discouraged; (4) Financial support for candidates to make telephone calls to AMA House members is acceptable; and (5) Lavish parties given exclusively for a candidate are discouraged. (Substitute Resolution 5, I-84) (Reaffirmed Report C, I-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)

520.000R **AMA: HOUSE OF DELEGATES**

520.001R Residents in the AMA House of Delegates: That: (1) our AMA-RFS Governing Council include in the AMA-RFS Assembly handbook a semiannual report detailing information on AMA-RFS members sitting in the AMA House of Delegates including, but not limited to, name and state or specialty society representation; and (2) invite all resident members of the AMA House of Delegates to the AMA-RFS Assembly and caucuses. (Resolution 26, A-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)

520.002R AMA House of Delegates Election Reform: That the AMA-RFS support that the AMA create a speaker-appointed task force to re-examine election rules and logistics including regarding social media, emails, mailers, receptions and parties, ability of candidates from smaller delegations to compete, balloting electronically, and timing within the meeting, and to report back recommendations regarding election processes and procedures to accommodate improvements to allow delegates to focus their efforts and time on policy-making. (Late Resolution 1, A-19)

520.003R Transparency of Resolution and Report Fiscal Notes: That our AMA-RFS support that resolutions or reports with recommendations to the AMA House of Delegates meets the following guidelines: A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of any proposed study or directive to take action shall be generated and published by AMA staff in consultation with the sponsor prior to its acceptance as business of the AMA House of Delegates. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in the AMA House of Delegates Handbook to justify each fiscal note (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that

proposes, studies or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy. [See also AMA Policy D-600.061] (Alternate Resolution 3, I-21)

520.004R Dissolution of the Resolution Committee: That our AMA-RFS support the AMA in removing the Interim Meeting focus requirement by the deletion of the AMA Bylaws B-2.12.1.1 “Business of Interim Meeting,” and B-2.13.3 “Resolution Committee.” (Resolution 9, I-21)

520.005R Opposition and Stance on a Permanent Reference Committee: That our AMA-RFS strongly opposes the use of a Resolution Committee or similar “representative” body to filter out resolutions from the business of the HOD without the opportunity for universal extraction, and be it further; and (b) if a Resolution Committee is to inevitably be established, that our AMA-RFS will advocate for the following composition and rules: (1) Members representing the RFS and MSS shall be appointed by their respective Governing Councils for a one-year term; (2) The composition of the Resolution Committee will be representative of AMA membership; (3) Resolution Committee members will be term limited and cannot serve for more than four years in total; and (4) The Resolution Committee shall meet at least once to discuss all resolutions prior to voting. Resolutions submitted later by those societies or sections that meet after the resolution deadline (i.e. resolutions normally included in the Tote) will be discussed by the Resolution Committee and voted on prior to the publication of the Resolution Committee report; (5) Members will rank each resolution by priority on a single 0-to-5-point scale. The median score will be used to rank resolutions. A threshold for inclusion can be recommended, but extraction from the report will be possible for all resolutions; (6) Extraction of a resolution from the Resolution Committee report shall only be prevented by a two-thirds vote of the House of Delegates; (7) The deliberations of the Resolution Committee will be free of input or influence from the AMA Board of Trustees, Presidents, Speakers, or Councilors; and If a resolution committee is not established by Annual 2023, this Resolved shall be removed from the AMA-RFS policy digest. (Emergency Resolution 1, A-22)

530.000R **AMA: MEMBERSHIP AND DUES**

530.001R Acaademic Medical Center Resident and Fellow Recruitment: That our AMA-RFS: (1) coordinate and facilitate current membership recruitment programs, such as the Resident Outreach Program, with the AMA and state medical societies; and (2) coordinate with AMA staff, Graduate Medical Education Designated Institutional Officials (DIOs), GME Directors, and/or GME Coordinators to facilitate and expand resident recruitment to the AMA at resident/fellow orientation. (Resolution 7, A-04) (Reaffirmed Report D, I-14)

530.002R Definition of a Resident: That our AMA-RFS define a “resident” to include the following: (1) Members serving as their primary occupation in residencies approved by the ACGME or AOA; (2) Members serving as their primary occupation in fellowships approved as residencies by the ACGME or AOA; (3) Members serving fellowships in structured clinical training programs for periods of at least one year, to broaden competency in a specialized field, whether or not the program is affiliated

with an approved residency training program; (4) Members serving, as their primary occupation, in a structured educational program to broaden competency in a specialized field, provided it is begun upon completion of medical school, residency, or fellowship training; (5) Members serving as active duty military and public health service residents who are required to provide service after their internship as general medical officers or flight surgeons before their return to complete a residency program. (Report K, A-97) (Reaffirmed Report D, I-16)

540.000R AMA: POLITICAL ACTION

540.001R Election Day Voting Time: That our AMA-RFS: (1) encourage state medical societies to inform residents and students of local voter laws to include education on absentee balloting; and (2) encourage medical schools and residency training programs to define mechanisms specific to their institution to allow residents and students the opportunity to vote in local and national elections. (Substitute Resolution A-95) [See also: AMA Policy H-565.991] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

540.002R Creating Legislative Visitation Programs: That our AMA-RFS: (1) encourage state medical associations and specialty societies to create programs that will enable resident physicians to participate directly in the legislative process at the state level; and (2) encourage state medical associations and specialty societies choosing to create legislative visitation programs to consider the Florida Medical Association's Legislative Visitation Program as a possible model in designing their own such programs. (Resolution 1, A-95) [See also: AMA Policy H-565.992] (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

550.000R AMA-RFS: ADMINISTRATION AND ORGANIZATION

550.002R Expanding Underrepresented Minority Voices in the AMA-RFS: That the AMA-RFS: 1) create bylaws to specifically and systematically outline how a minority physician organization may gain representation in the RFS national assembly; 2) research the major underrepresented minority physician organizations with a focus on the level of involvement of resident and fellow members in each organization, on the percentage of AMA members in each organization, and on the level to which each minority physician organization desires to be involved with the AMA-RFS; 3) leadership work with the Specialty and Service Society (SSS) to determine the needed steps that minority physician organizations would have to take to become seated members of the AMA-HOD. (Report F, I-08)

550.003R AMA-RFS Strategic Plan: Vision, Mission, and Objectives: That our AMA-RFS utilize the vision, mission and objectives set forth by the AMA-RFS Committee on Long Range Planning as a foundation for further planning. (Report E, A-01) (Reaffirmed Report D, I-16)

550.004R AMA-RFS Leadership Handbook: That: (1) our AMA-RFS staff and Governing Council design a Leadership Handbook outlining the structure and function of the RFS, leadership positions, and state society contacts; (2) that our AMA-RFS

encourage state, county, and specialty societies to develop similar materials; and (3) that our AMA-RFS make the Leadership Handbook available at the Annual and Interim Meetings and upon request. (Substitute Resolution 3, I-97) (Reaffirmed Report C, I-07)

550.005R Centralized Resource for Listing Residency and Fellowship Vacancies: That our AMA-RFS work to create and maintain a centralized resource that lists available residency and fellowship vacancies for its membership. (Substitute Resolution 25, A-97) (Reaffirmed Report C, I-07)

550.006R AMA Support for Section Web Pages: That our AMA-RFS: (1) maintain the AMA-RFS Home Page, managed by AMA staff in conjunction with an RFS Computer Advisory Committee designee; and (2) procure and maintain space on the AMA server. (Substitute Resolution 13, I-95) (Reaffirmed Report C, I-05) (Reaffirmed Report E, A-16)

550.007R Fiscal Affairs of the Resident and Fellow Section: That the Governing Council to provide an annual fiscal report for the previous year at the Annual Meeting. (Substitute Resolution 18, A-78) (Reaffirmed Report C, I-88) (Reaffirmed Report C, I-98) (Reaffirmed Report D, I-16)

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

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

In the realm of Membership and Outreach: (7) The RFS and RFS Governing Council should investigate mechanisms to increase retention of members as they transition from one section to another, including: a) members transitioning from the MSS to

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

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

In general, the Committee recommends that: (17) the RFS recommend that a Working Plan be developed by the Committee on Long Range Planning for the RFS Governing Council and approved by the assembly at least every 3 years. (Late Report H, I-13)

550.009R Solicitation of the AMA Brand: That our AMA-RFS support the AMA in studying the use of AMA branded solicitation material mailed to physicians, the impact it has on the perception of our AMA by current and potential physician members, and the merits of continuing to use these materials in future communications; and studying our membership on the preferred method to receive third party solicitation material (mail, phone, email, social media) and provide a method to opt-out of certain methods if not desired. (Resolution 2, I-21)

550.010R Editorial Changes to Outdated and Stigmatizing Language in the RFS Digest of Actions: That our AMA-RFS review our RFS position statements to editorially update outdated and stigmatizing language as guided by “Advancing Health Equity: A guide to language, narrative, and concepts” on a regular basis, with the language reflected in the Sunset Report; and that our AMA-RFS will use clinically accurate,

non-stigmatizing terminology in all future resolutions, reports, and educational materials and discourage the use of stigmatizing terms. (Resolution 11, A-23)

550.011R Inclusion of All Passed Resolutions in the RFS Digest of Actions: That our AMA-RFS retain all resolutions passed in RFS assembly in our RFS Digest of Actions, including those that pass at the AMA House of Delegates; and that our AMA-RFS study past versions of our RFS Digest of Actions with a lookback period of up to 10 years to restore RFS policy that passed at the AMA House of Delegates and was subsequently removed. (Resolution 12, A-23)

550.012R Updating Language Regarding Families and Pregnant Persons: That our AMA-RFS review and update the language used in our RFS Digest of Actions, and other resources and communications, to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures; and that our AMA-RFS support our AMA in reviewing and updating the language used in AMA policy, and other resources and communications, to ensure that the language used to describe families and persons in need of obstetric and gynecologic care is inclusive of all genders and family structures. (Resolution 13, A-23)

560.000R **AMA-RFS COUNCILS AND COMMITTEES**

560.001R Standing Committees: That our AMA-RFS Governing Council shall annually appoint standing committees including, but not limited to, long range planning, public health, medical education, legislative awareness, membership and the poster symposium, composed of members of the Section to serve annual terms to further the mission of the Section; 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 in order to adequately staff these committees, the Governing Council shall be empowered to make direct solicitations and appointments to the committees. (Report E, A-08)

560.003R Resident Representation on Residency Review Committees: That our AMA consider appointing resident physicians to residency review committees currently without resident members by using its ex-officio positions on the committees. (Substitute Resolution 1, A-87) (Reaffirmed Report D, I-97) [See also: AMA Policy H-310.996] (Reaffirmed Report D, I-16)

560.004R Resident Representation on the Internal Medicine Residency Review Committee: That our AMA request all Residency Review Committees utilize peer-selected resident representatives to serve as voting members at all meetings of the committee for at least a one year term preceded by a six month term as an observer. (Substitute Resolution 2, A-98) (Reaffirmed Report D, I-16)

560.005R Peer-Nominated Representation on Institutional Councils and Committees: That our AMA-RFS: (1) encourage the ACGME to require that resident representatives on institutional GME Committees be peer-selected and (2) study ways to ensure that the resident representatives on institutional GME Committees play a meaningful role at their institutions. (Substitute Resolution 9, I-99) (Reaffirmed Report C, I-09)

- 560.006R** On the Creation of an RFS JEDI Committee: 1. That our AMA-RFS formally found a Justice, Equity, Diversity, and Inclusion (JEDI) Standing Committee.
2. That the description of the AMA-RFS JEDI Standing Committee be as follows: Justice, Equity, Diversity, and Inclusion (JEDI) Standing Committee: This committee is dedicated to strengthening our Resident-Fellow Section through the promotion of justice, equity, diversity, and inclusion. The committee aims to build justice and equity into our policy, advocacy, and business, and to ensure that the full diversity of resident and fellow membership is represented, welcome, and supported as members and in leadership. Committee members also work with the Governing Council and other stakeholders to create educational programming and policy.
3. That the responsibilities of the AMA-RFS JEDI Standing Committee be as follows:
(a) Review of RFS resolutions and programming/webinar proposals for their impact on JEDI-related topics and collaboration to strengthen RFS policy for JEDI-related causes;
(b) Regular creation and curation of JEDI-related content and programming for the RFS;
(c) Act as liaisons with other JEDI-related groups within the AMA;
(d) As-needed advocacy within our RFS and the AMA for greater support and implementation of JEDI within our organization and within healthcare. (Report B, A-23)

570.000R **AMA-RFS: GOVERNING COUNCIL**

- 570.002R** Communication between the AMA-RFS Governing Council and State Society Resident and Fellow Sections: That our AMA-RFS (1) establish a list of state and specialty society resident physicians section chairpersons; and (2) publish a list of state and specialty society resident physicians section chairpersons in the Annual and Interim Assembly meeting handbooks and proceedings. That our AMA-RFS Governing Council attempt to contact each state and specialty society resident physicians section chairperson prior to each AMA-RFS Assembly meeting. (Substitute Resolution 7, I-91) (Reaffirmed Report C, I-01) (Reaffirmed Report D, I-16)

580.000R **AMA-RFS ASSEMBLY**

- 580.002R** AMA-RFS Strategic Plan: The following strategic plan for AMA- RFS was adopted for 2010-2011:

In the realm of Membership:

1. The RFS should work with the MSS, membership staff, YPS, and County and State medical societies, to develop longitudinal membership drive initiatives that encompass all aspects of physician training from medical school graduation to completion of residency and fellowship training;
2. The AMA-RFS should ensure that there is an RFS-GC member and staff member who is in regular contact with the AMA membership staff and who will serve in an advisory role to the membership department in regards to the creation and implementation of RFS membership initiatives;

3. The AMA-RFS should work with the AMA membership staff to research and develop new membership incentives tailored to prospective RFS members

In the realm of Advocacy:

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

In the realm of Communication:

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

In the realm of the RFS Regions:

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

In General the Committee recommends that:

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

580.004R Demographics: That our RFS: (1) determine mechanisms to strengthen ties with Specialty Societies and improve logistical support for members involved through their Specialty Societies (i.e. Region 8); (2) determine a system to apportion Specialty Society delegate and alternate delegate positions in the RFS assembly that accounts for the number of RFS members represented by Specialty Societies and ensures broad Specialty Society participation; (3) examine the ability of the Region structure to meet the stated goals of disseminating RFS information to local members, increasing RFS membership, and increasing involvement of RFS members at the regional and local level; and (4) that the RFS Governing Council report back to the RFS Assembly regarding the progress of the above recommendations by A-09. (Report G, A-08)

- 580.008R** Election Bylaws: That our AMA-RFS Governing Council design and implement an educational program for the Assembly to clarify the vote counting method for rank order balloting. (Substitute Resolution 1, I-99) (Reaffirmed Report C, I-09)
- 580.009R** AMA-RFS External Resolutions: That our AMA-RFS include in the AMA-RFS delegate package and in the AMA-RFS Handbook information explaining the options for each resolution and the process for determining how resolutions are forwarded to either the AMA-RFS assembly and/or the AMA-HOD. (Substitute Resolution 5, I-97) (Reaffirmed Report C, I-07)
- 580.010R** Background Information on Resident and Fellow Section Resolutions: That our AMA-RFS require the authors of resolutions to provide pertinent references and relevant existing AMA policy on the issue. (Substitute Resolution 9, A-97) (Reaffirmed Report C, I-07)
- 580.011R** Meeting Notices: That our AMA-RFS will include a schedule of annual and interim meeting dates, locations, and hotels in the AMA-RFS Handbook, proceedings, and other appropriate publications. (Substitute Resolution 9, A-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)
- 580.012R** Fiscal Notes Attached to Resolutions: That our AMA-RFS staff contact the author or sponsoring medical society of any AMA-RFS resolution that assigned a fiscal note over \$1,000. (Substitute Resolution 4, I-92) (Reaffirmed Report C, I-02) (Reaffirmed Report D, I-12) (Reaffirmed Report E, A-22)
- 580.015R** RFS Reference Committee Reports: That: (1) AMA-RFS members not on the reference committee not be admitted to its executive session unless invited; and (2) members of a reference committee write and/or review its report prior to the presentation of its findings to the AMA-RFS Assembly. (Resolution 7, A-80) (Reaffirmed Report C, I-90) (Reaffirmed Report C, I-00) (Reaffirmed Report C, I-10)
- 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)
- 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 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)

580.020R Naming Conventions for AMA-RFS Policy/ Internal Operating Procedures Revision: That our AMA-RFS will form an ad-hoc committee broadly representing the membership of the Assembly for the purpose of reviewing and revising the AMA-RFS IOPs with a progress report at I-18. (Resolutions 1,17, A-18)

590.000R **AMA-RFS: MEMBERSHIP AND DUES**

590.001R Update on the 50 State Membership Initiative: That our AMA-RFS

1. Membership Committee work with AMA-RFS Staff to continuously update state and specialty society RFS information as outlined in the Late Report 1 (A-09).
2. Membership Committee work with AMA-RFS Staff to obtain the necessary information in order to utilize the flow chart model (see Supplement 1) for state RFS leadership contact information and also utilize this model in order to appoint RFS leadership where necessary and possible.
3. Membership Committee provide updated informational reports of the Fifty State Resident and Fellow Membership Initiative at I-10 and A-11.
4. Governing Council and the Membership Committee work with each state and specialty society RFS to increase membership and encourage increased participation and activity of its membership both at the state and national level.
5. Governing Council and the Membership Committee encourage and assist with the formation of RFS in those states that do not have a formally organized RFS but have an active and interested group of physicians in training as recommended in Late Report 1 (A-09). (Report I, A-10)

- 590.002R** Enhancement of Membership Retention During Educational Transitions: That our AMA develop systems to allow state medical associations access to medical student match data and membership information for the purpose of membership retention and outreach without breaching existing contractual obligations; That our AMA study means to improve communication between state medical associations and our AMA for purposes of membership, recruitment, and retention, particularly during times of transition between medical school, residency, and fellowship. (Resolution 7, A-10)
- 590.003R** Enhancing Involvement of New Meeting Attendees: That our RFS-CLRP develop specific criteria for the use of At-Large positions; That the RFS pilot the use of At-Large positions and a program to incorporate new attendees and non-voting members into existing positions, within the purview of our AMA-RFS IOPs as well as state and specialty society procedures, prior to the commencement of the meeting at I-10; That the RFS-CLRP report the results of the pilot at A-11 and the Assembly vote to determine if the pilot becomes permanent. (Report H, A-10)
- 590.004R** Developing a Mentoring Program for New AMA-RFS Attendees: That our AMA-RFS work to create a mentoring program to welcome new attendees to the section's meetings including, but not limited to, linking mentors and mentees of the same region to sit near each other during RFS business, apprising the mentee of evening social activities, and contacting the mentee before the subsequent meeting. (Report L, I-09)
- 590.005R** Expanding AMA Participation by Minority Scholar Award Winners: That our AMA-RFS increase recruitment and retention of future award winners (including minority scholar award winners) by developing a strategic plan for leadership development and that our AMA-RFS report back on this issue at A-09. (Resolution 8, A-08)
- 590.006R** Resident and Fellow Section Recruitment Funding Initiative: That our AMA-RFS support: (1) our AMA working with the Membership Group to formalize a model based on MSSOP with reward monies awarded directly to State RFS sections; (2) our AMA requesting that the current MSSOP Resident Recruitment Awards be extended to the RFS sections of State Medical Societies for each new member recruited above the previous year state membership total set July 1st of each year; (3) our AMA requesting that membership for the RFS section be changed to an academic calendar year from the current calendar year cycle; (4) our AMA requesting a permanent staff member within the Membership Department dedicated to resident/fellow recruitment and retention on a yearly basis; (5) the Membership Group identifying yearly the staff contact within each state medical society responsible for resident membership issues and provide this list to the Department of Resident and Fellow Services; (6) our AMA requesting formal market research on current AMA residents, non-active AMA residents, residents who have never been part of the AMA, and residency programs assessing the factors that affect membership. (Report F, A-03) [HOD Resolution 613] (Reaffirmed Report D, I-16)
- 590.007R** Resident and Fellow Section Recruitment Funding Initiative: That our AMA-RFS Governing Council work with the membership committee to develop a membership program modeled after the MSS, whereby the AMA provides incentive at the local or state level, based on membership recruitment, in order to encourage increased

recruitment as well as provide the necessary funds to increase active participation in the RFS section. (Substitute Resolution 7, I-02) (Reaffirmed Report D, I-16)

590.008R Medical Student Retention in the RFS: That our AMA-RFS request the AMA Membership Department to provide the State Medical Society Resident and Fellow Section Chairs with a list of fourth year medical students members in their state. (Resolution 3, A-02) (Reaffirmed Report D, I-16)

590.009R Facilitating a Smoother Transition Through the Medical Student Section (MSS), Resident and Fellow Section (RFS), and Young Physician Section (YPS): That our AMA-RFS work with the MSS and the Young Physician Section (YPS) to implement methods to facilitate the transition between the sections. (Substitute Resolution 8, A-97) (Reaffirmed Report C, I-07)

590.010R American Medical Association Resident Outreach Program: That our AMA-RFS: (1) continue to work with AMA Membership marketing to develop new campaigns for resident physician recruitment; and (2) Governing Council report to the Assembly on the progress of these programs. (Substitute Resolution 32, A-94) (Reaffirmed Report F, A-05) (Reaffirmed Report E, A-16)