

Reference Committee C

CME Report(s)

01 Access to Confidential Health Services for Medical Students and Physicians

Resolution(s)

301 Expanding the Treatment of Opioid Dependence Using Medication-Assisted Treatment by Physicians in Residency Training Programs

302 Protecting the Rights of Breastfeeding Residents and Fellows

303 Primary Care and Mental Health Training in Residency

304 Improving Access to Care and Health Outcomes

305 Privacy, Personal Use and Funding of Mobile Devices

306 Formal Leadership Training During Medical Education

307 Inappropriate Uses of Maintenance of Certification

308 Promoting and Reaffirming Domestic Medical School Clerkship Education

309 Development of Alternative Competency Assessment Models

310 Maintenance of Certification and Insurance Plan Participation

311 Prevent Maintenance of Certification Licensure and Hospital Privileging Requirements

312* Eliminating the Tax Liability for Payment of Student Loans

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-16)
Access to Confidential Health Services for Medical Students and Physicians
(Resolution 901-I-15, Resolution 913-I-15, Resolution 304-A-16)
(Reference Committee C)

EXECUTIVE SUMMARY

This report is in response to AMA Policy D-405.983, “Medical Students and Residents as Patients,” and to Resolution 901-I-15, “Access to Mental Health Care for Medical Trainees”; Resolution 913-I-15, “Mental Health Services for Medical Staff”; and Resolution 304-A-16, “Evaluation of Factors During Residency and Fellowship that Impact Routine Health Maintenance.”

To ensure a holistic approach to this issue, the scope of this report has been expanded beyond access to mental health care services to encompass confidential access to all health services. That said, it should be emphasized that the provision of mental health services, and the confidentiality of this care, is a critical need throughout medical education training and practice and presents some challenges in the inherently imbalanced relationship(s) between and among teachers and learners.

This report provides an overview of the issue and its challenges vis-à-vis the culture of medicine writ large and then examines potential solutions by a number of key stakeholders, including: 1) accrediting agencies, 2) medical institutions, including medical schools, residency/fellowship programs, employers, hospitals, and 3) professional associations, particularly the AMA.

Issues cited include 1) The mental and physical toll that medical education exacts on medical students and physicians, as they seek to balance their personal lives with the need to master a growing body of knowledge and develop the needed skills to practice medicine; 2) The “hidden curriculum” of medical education, which can expose students/learners to an unhealthy emotional environment and contribute to burnout; 3) The long-standing and deeply ingrained stigma against physicians seeking care for either physical or mental health issues, partly due to concerns of career and licensure implications; 4) Issues with confidentiality of care, particularly in training or practice settings in more isolated, rural areas or small towns, as a significant barrier to seeking needed services; and 5) Acculturation during medical education and training to ignore one’s own personal health needs rather than expose colleagues and team members to an even more onerous work load.

Through the work of two of its strategic focus areas, 1) Accelerating Change in Medical Education and 2) Professional Satisfaction and Practice Sustainability, the AMA can play a key role, alongside other stakeholders, in addressing these systemic issues in medical education and practice and ensuring a healthier health care environment, to the ultimate benefit not only of medical students and physicians but patients as well.

The report’s recommendations include revisions to existing AMA policy on medical student and physician health, to streamline and consolidate this policy into a more cohesive, coherent body. These recommendations do not reflect new policy directives for the AMA.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-16

Subject: Access to Confidential Health Services for Medical Students and Physicians
(Resolution 901-I-15, Resolution 913-I-15, Resolution 304-A-16)

Presented by: Patricia L. Turner, MD, Chair

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

1 INTRODUCTION

2
3 This report of the Council on Medical Education is in response to the following American Medical
4 Association (AMA) Policy and to the three resolutions noted below, which were referred by the
5 House of Delegates:

- 6
7 • Policy D-405.983, “Medical Students and Residents as Patients,” which directs the
8 American Medical Association (AMA) to study ways to address the power dichotomy
9 between physicians and medical students, residents and fellows as it relates to these
10 trainees’ care as patients.
- 11
12 • Resolution 901-I-15, “Access to Mental Health Care for Medical Trainees” (introduced by
13 the Indiana Delegation), which asks that the AMA: 1) Support the provision of on-campus
14 mental health care in medical schools and residency programs that goes beyond supportive
15 counseling; and 2) Encourage ongoing and future initiatives by medical schools and
16 residency programs to provide urgent and emergent access for all medical trainees to
17 psychiatrists that could include an in-house board-certified psychiatrist.
- 18
19 • Resolution 913-I-15, “Mental Health Services for Medical Staff” (introduced by the
20 Resident and Fellow Section), which asks that the AMA encourage health systems,
21 hospitals, and medical schools to offer physicians and medical students access to
22 confidential and comprehensive mental health services not affiliated with their place of
23 employment.
- 24
25 • Resolution 304-A-16, “Evaluation of Factors During Residency and Fellowship that
26 Impact Routine Health Maintenance” (introduced by the Resident and Fellow Section),
27 which asks that the AMA study ways to improve access and reduce barriers to seeking
28 preventive and routine physical and mental health care for trainees in graduate medical
29 education programs.
- 30

31 For Resolutions 901-I-15 and 913-I-15, testimony before Reference Committee K at the 2015
32 Interim Meeting emphasized the importance of making confidential and comprehensive mental
33 health services available to medical students and resident/fellow physicians. It was noted that
34 Liaison Committee on Medical Education (LCME) accreditation standards require medical schools
35 to provide medical services at sites in reasonable proximity to the locations of their required
36 educational experiences, and that the LCME collects data on access to psychiatric services and

1 student satisfaction with mental health services. It was also noted that this item is consistent with
2 the work being done by the Accreditation Council for Graduate Medical Education (ACGME) to
3 support trainee well-being, through such efforts as the ACGME Clinical Learning Environment
4 Review process. There was concern expressed during testimony about providing students and
5 residents access to in-house psychiatrists for urgent and emergent care. It was noted that a
6 psychiatrist located in reasonable proximity to training sites would be the most appropriate
7 caregiver so that students and residents would not be obligated to receive care from a physician
8 who is involved in their academic assessment and advancement. Other factors related to
9 Occupational Safety and Health Administration (OSHA) standards and occupational health care
10 regulations also need to be considered, as well as the health of physicians beyond training years.
11

12 For Resolution 304-A-16, significant testimony was provided to Reference Committee C at the
13 2016 Annual Meeting, reflecting the importance of this timely issue, as the epidemic of physician
14 burnout and suicide continues unabated. Testimony noted the work of the AMA in exploring and
15 disseminating solutions, through its Professional Satisfaction and Practice Sustainability strategic
16 focus area, for example, and educational sessions on the topic during the 2016 Annual Meeting. It
17 was also noted that the Accreditation Council for Graduate Medical Education, through its
18 Physician Well-Being initiative (as described further below), is actively addressing the issues of
19 physician burnout, wellness and resiliency. Additional testimony noted issues of confidentiality in
20 accessing needed care, especially in smaller cities and towns; the reluctance among trainees to seek
21 care due to fear of burdening their residency colleagues with having to cover for their absence; and
22 the need to change the culture of medicine to enhance physician well-being and work-life balance.
23

24 BACKGROUND

25
26 To ensure a holistic approach to this issue (and in light of the need to respond to Resolution 304-A-
27 16), the scope of this report has been expanded beyond access to mental health care services to
28 encompass confidential access to all health services. That said, it is important to emphasize that the
29 provision of mental health services, and the confidentiality of this care, is a critical need throughout
30 medical education training and practice and presents some challenges in the inherently imbalanced
31 relationship(s) between and among teachers and learners. Although Policy D-405.983 calls for
32 studying this imbalance, the real priority (and the objective for this report) is how to address this
33 imbalance so that medical students and resident/fellow physicians can receive appropriate care
34 without fear of stigma or repercussions.
35

36 This report provides an overview of the issue and its challenges vis-à-vis the culture of medicine
37 writ large and then examines potential solutions by a number of key stakeholders, including:
38 1) accrediting agencies; 2) medical institutions, including medical schools, residency/fellowship
39 programs, employers, hospitals; and 3) professional associations, particularly the AMA.
40

41 THE NEED FOR MEDICAL STUDENT AND PHYSICIAN ACCESS TO CARE

42
43 Interest in physician health and wellness has increased significantly over the last few years, as
44 stressors in medical education and practice exact a mental and physical toll on medical students and
45 physicians. Those at the early stages of their careers—medical students and resident/fellow
46 physicians—are undergoing the challenges of balancing their personal lives with the need to master
47 a growing body of knowledge and develop the needed skills to practice in a changing health care
48 environment. What is often called the “hidden curriculum” of medical education can expose
49 students/learners to an unhealthy emotional environment and can contribute to burnout. Residency
50 training, in particular, can be a daunting endeavor for many, despite the implementation of duty

1 hour limits. For some, the personal and professional stresses become too great, leading to
2 emotional distress, burnout, major depression, and, in extreme cases, suicide.

3
4 Indeed, a study in the Dec. 8, 2015 issue of *JAMA* found that nearly one-third of interns and
5 residents experience depressive symptoms or full-blown depression at some point during their
6 training. The prevalence of depression among trainees is significantly higher among medical
7 residents than the general population (about 7 percent of all U.S. adults had at least one major
8 depressive episode during the previous year, according to the National Institute of Mental Health).

9
10 Similarly, more than half of U.S. physicians “experienced at least one symptom of burnout in 2014,
11 compared to about 46 percent of doctors in 2011,” notes coverage of a *Mayo Clinic Proceedings*
12 study released on Dec. 1, 2015. These data point to the need for interventions for all physicians and
13 physicians-in-training to learn techniques for ensuring wellness, managing burnout when
14 symptoms arise, and improving emotional resiliency to professional and personal challenges.

15
16 Without serious attention to physician wellness, physicians may retire earlier or leave medicine for
17 another field, further exacerbating medical workforce shortages and reducing access to needed care
18 among patients. Even for those who remain in practice, burnout can have substantial professional
19 and patient safety implications. An extensive body of research has demonstrated a strong link
20 between physicians’ personal well-being and the quality of care they provide patients, as well as a
21 positive relation between physicians’ and patients’ preventive health practices.¹ Finally, as role
22 models and mentors to those who will serve as the nation’s future physicians, academic physicians
23 must develop a better understanding of the importance of and need for wellness so that they can
24 help their mentees succeed.

25
26 From a systemic perspective, the stigma against physicians seeking care for either physical or
27 mental health issues is long-standing and deeply ingrained. Generalizations about generational
28 differences come into play as well, with a commonly held stereotype in medicine that today’s
29 “kids” (the Millennials, for example) are not as committed to medicine and their patients as their
30 predecessors and lack the requisite work ethic to be physicians. Long hours and commitment to
31 patients are praised, and attention to self-care or healthy lifestyles/prevention may be seen as self-
32 indulgent or indicative of a lack of dedication. Little or no confidentiality, particularly in training or
33 practice settings in more isolated, rural areas or small towns, can be a barrier to seeking needed
34 services. During training, many resident/fellow physicians are acculturated to ignore their own
35 personal health needs (sleep, for example) and are loath to miss a shift and expose colleagues and
36 team members to an even more onerous work load. Many physicians develop a “survival”
37 mentality during medical school and training, which extends throughout their careers, with
38 unfortunate consequences for personal health and well-being as well as work-life balance and
39 interpersonal and family relationships.

40
41 Physicians who continue to work when sick and who routinely ignore their own health needs to
42 provide care to their patients may be unintentionally endangering those very patients—e.g., by
43 exposing them to contagions or infection if they come to work while sick, or to unintentional injury
44 if they are not well-rested. As noted in the *AMA Code of Medical Ethics* 9.3.1, “Physician Health
45 & Wellness” (included in the appendix of this report), “When physician health or wellness is
46 compromised, so may the safety and effectiveness of the medical care provided. To preserve the
47 quality of their performance, physicians have a responsibility to maintain their health and wellness,
48 broadly construed as preventing or treating acute or chronic diseases, including mental illness,
49 disabilities, and occupational stress.” The policy also notes that physicians should take “appropriate
50 measures to protect patients, including measures to minimize the risk of transmitting infectious
51 disease commensurate with the seriousness of the disease.”

1 These attitudes and behaviors may be gradually shifting—particularly as more physicians enter into
2 employment versus solo practice—but the enduring power of the “medical-institutional complex”
3 and the attitudes of attending physicians and faculty (upon whose approval/satisfaction one’s career
4 rests) may ensure the perpetuation of an ultimately unhealthy hidden curriculum and culture. For
5 example, one medical student, who decided to be outspoken about her own personal mental health
6 struggles, wrote, “Dealing with academic administration is an awful part of med school. It’s a
7 medieval-like process of judgment and punishment to ask for help or find yourself struggling with
8 all the exams.”²

9
10 In addition, a significant number of mental health professionals do not accept insurance. A recent
11 news report notes, “[N]early half of therapists in California don’t take insurance, according to a
12 recent survey from the California Association of Marriage and Family Therapists. The same is true
13 of psychiatrists.”³ This widespread lack of insurance coverage presents another barrier to medical
14 students and resident/fellow physicians seeking mental care services and counseling.

15
16 The extent of these pernicious issues and challenges throughout medical education and practice call
17 for a variety of individual, institutional, and systemic (cultural) solutions. When learners/
18 employees access medical/behavioral services from teachers/employers, the potential exists for
19 troublesome conflicts of interest, confidentiality concerns, and related issues. As noted in the
20 following sections, key stakeholders in this process include: 1) accrediting agencies; 2) medical
21 institutions, including medical schools, residency/fellowship programs, employers, hospitals; and
22 3) the AMA and other professional associations and related bodies.

23 24 THE WORK OF ACCREDITING AGENCIES

25 26 *Liaison Committee on Medical Education (LCME)*

27
28 Relevant LCME standards (now called “Elements”) are included below (note that the LCME
29 defines personal counseling to include psychiatric and psychological services):

30 31 12.5 Non-Involvement of Providers of Student Health Services in Student Assessment/ 32 Location of Student Health Records

33 The health professionals who provide health services, including psychiatric/psychological
34 counseling, to a medical student have no involvement in the academic assessment or promotion
35 of the medical student receiving those services. A medical school ensures that medical student
36 health records are maintained in accordance with legal requirements for security, privacy,
37 confidentiality, and accessibility.

38 39 12.4 Student Access to Health Care Services

40 A medical school provides its medical students with timely access to needed diagnostic,
41 preventive, and therapeutic health services at sites in reasonable proximity to the locations of
42 their required educational experiences and has policies and procedures in place that permit
43 students to be excused from these experiences to seek needed care.

44 45 12.3 Personal Counseling/Well-Being Programs

46 A medical school has in place an effective system of personal counseling for its medical
47 students that includes programs to promote their well-being and to facilitate their adjustment to
48 the physical and emotional demands of medical education.

1 *Commission on Osteopathic College Accreditation (COCA)*

2
3 Relevant standards from the COCA are as follows:

4 5.5.7 The COM [College of Medicine] and/or its parent institution must make available to
5 students confidential resources for physical healthcare services.

6
7 5.5.8 The COM and/or its parent must make available to students on a 24 hour per day 7
8 days a week (“24/7”) basis, confidential resources for behavioral healthcare services.⁴

9
10 *Accreditation Council for Graduate Medical Education (ACGME)*

11
12 Through its Physician Well-Being initiative, the ACGME is engaging in a national dialogue on this
13 issue to ensure positive, transformational change in the learning environment. Beginning with a
14 symposium in November 2015, medical education organizations representing accreditation,
15 assessment, and certification, along with the AMA, have joined the ACGME in prioritizing this
16 issue. As noted on the initiative’s website, the following areas of focus have been identified:

- 17
18 • Physician well-being is an individual and a system issue, and needs to be addressed on
19 both levels.
20 • Alignment between institutional leadership and faculty members in the learning
21 environment is necessary to create a culture of respect and accountability for physician
22 well-being.
23 • The well-being of physicians as caregivers is crucial to their ability to deliver the safest,
24 best possible care to patients.

25
26 Although the ACGME does not have specific accreditation standards on resident wellness and
27 confidential access to health care services, certain standards are relevant to this topic. For example,
28 its Institutional Requirements⁵ state:

29
30 Behavioral Health: The Sponsoring Institution must provide residents/fellows with access to
31 confidential counseling and behavioral health services.

32
33 Physician Impairment: The Sponsoring Institution must have a policy, not necessarily GME-
34 specific, which addresses physician impairment.

35
36 The Sponsoring Institution must ensure a healthy and safe learning and working environment
37 that provides for:

- 38
39 • access to food while on duty at all participating sites;
40 • safe, quiet, and private sleep/rest facilities available and accessible for
41 residents/fellows to support education and safe patient care; and
42 • security and safety measures appropriate to the participating site.

43
44 Meanwhile, the ACGME Common Program Requirements,⁶ in the section “Resident Duty Hours in
45 the Learning and Working Environment,” state:

46
47 Programs and sponsoring institutions must educate residents and faculty members concerning
48 the professional responsibilities of physicians to appear for duty appropriately rested and fit to
49 provide the services required by their patients.

1 The program must be committed to and responsible for promoting patient safety and resident
2 well-being in a supportive educational environment.
3

4 In addition, these requirements state that residents and faculty members “must demonstrate an
5 understanding and acceptance of their personal role in the following,” including “recognition of
6 impairment, including illness and fatigue, in themselves and in their peers.”
7

8 The ACGME is in the process of updating the Common Program Requirements. Revision of
9 section VI of these requirements was in process at the time this report was written. These new
10 Common Program Requirements are likely to include a section on resident well-being. The
11 ACGME supports the fact that well-being is critical to the development of physicians and that self-
12 care is an important component of a physician’s professional life.
13

14 Finally, one of the six focus areas that is part of the ACGME’s Clinical Learning Environment
15 Review (CLER) program has been renamed to reflect a broader emphasis on physician well-being.
16 The ACGME Board of Directors approved the recommendation of the Executive Committee for
17 the CLER Evaluation Committee, such that the CLER focus area currently called “Duty
18 Hours/Fatigue Mitigation and Management” has been renamed “Well-Being,” effective July 1,
19 2017. This focus area will concentrate primarily on the Clinical Learning Environment’s systems-
20 based approaches to creating and maintaining an environment of well-being. It is anticipated that
21 the new focus area will include a number of pathways and properties that address fatigue, burnout,
22 work-life balance, and support of residents and faculty at risk or demonstrating self-harm. The
23 other five CLER focus areas are patient safety, health care quality, care transitions, supervision,
24 and professionalism.
25

26 *The Joint Commission*

27

28 Joint Commission standard MS.11.01.01 requires that medical staffs create a non-disciplinary
29 process by which licensed independent practitioners’ health issues can be identified and managed.
30 When the standard was first created, many hospitals implemented wellness committees with the
31 primary focus of detecting and reprimanding physicians struggling with addiction, stress, or other
32 issues that could negatively impact patient safety. More recently, however, an increased focus on
33 physician burnout by the medical community at large has led many of these groups to shift their
34 thinking and proactively offer tools and resources meant to alleviate stress and promote resiliency.
35

36 THE WORK OF MEDICAL INSTITUTIONS

37

38 Academic medical centers and regional health systems, medical schools, residency/fellowship
39 programs, teaching hospitals, and physician groups all have a role to play in addressing medical
40 student and physician health. Each type of organization can take action on this topic in different
41 ways.
42

43 For example, as described by the authors of a 2012 study in *Academic Medicine*,⁷ one teaching
44 hospital’s graduate medical education division has sought to address obstacles to resident/fellow
45 well-being by implementing a policy “that requires programs to assign residents four half-days off
46 per academic year for health care and wellness (physical and mental well-being).” The study,
47 which detailed gaps in personal health care practices of resident/fellow physicians, noted that this
48 population may be less likely than demographically similar non-physician peers to have a primary
49 care physician or seek routine health or dental care. Some of the concerns identified in the study
50 include a perception of lack of time to see a physician, lack of access to an appropriate physician,
51 and concerns about confidentiality and stigmatization (particularly as it relates to seeking mental

1 health services). In addition, with the introduction of the 16-hour work day requirements for first-
2 year resident physicians, many residency programs have gone to week- or month-long night float
3 rotations. The residents on night float, therefore, have additional time for personal well-being
4 visits. Residents on a more traditional day-work schedule, who in the past had part of their post-call
5 days free, now no longer take call. As a result, their post-call flexibility may be limited except
6 when they are assigned to the night float service.

7
8 For medical students and physicians seeking care, particularly those in more remote communities,
9 telemedicine may offer one way to supersede some of these issues—particularly the confidentiality,
10 access, and time/scheduling concerns that an on-site, face-to-face visit might present. As reflected
11 in Council on Medical Education Report 6-A-16, “Telemedicine in Medical Education,” this
12 modality offers multiple benefits and is growing in popularity. Indeed, a recent news article
13 describes how telemedicine kiosks are becoming more common, with an increasing number of
14 employers offering insurance coverage for telemedicine services and installing telemedicine kiosks
15 at work sites so employees can receive on-the-job medical advice.⁸

16
17 Another possible solution for institutions to consider, as described in a recent article in *Academic*
18 *Medicine*,⁹ is to apply the principles of the patient-centered medical home to improving care for
19 resident/fellow physicians. The authors suggest several interventions to improve access to care,
20 including “confidential care without perceived conflicts of interest in the training environment, co-
21 location of medical and mental health care, and accommodations for schedule constraints.” These
22 types of resources and support may be particularly useful for first-year resident physicians, who are
23 not as familiar as their senior colleagues with seeking and obtaining health care services in the
24 specific hospital/health system in which they are training.

25
26 Finally, as noted earlier in this report, a significant number of psychiatrists and other mental health
27 professionals do not accept insurance, which presents another barrier to medical students and
28 resident/fellow physicians obtaining needed care and counseling services. In Manhattan, for
29 example, and other large cities, mental health/counseling services are prohibitively expensive for
30 residents and fellows—\$350 to \$450 a session is common. To address this issue, New York-
31 Presbyterian, a sponsoring institution for 135 residency/fellowship programs, has developed
32 Housestaff Mental Health Services.¹⁰ Through this program, resident/fellow physicians can access
33 up to eight free, confidential sessions from a pool of attending psychiatrists who have been
34 identified as having a particular interest in and aptitude for working with housestaff. The institution
35 pays for the services; insurance is not billed. A director (who is a psychiatrist) triages the residents,
36 manages the program, and maintains a firewall of confidentiality between the trainees and anyone
37 in the graduate medical education enterprise. Program directors and institutional leadership (to
38 include the designated institutional official, for example) do not know who accesses these services;
39 the human resources department processes the billing. As for usage, currently about 10% of
40 housestaff access these services each year. The program is offered on each of New York-
41 Presbyterian’s two GME campuses. Aside from helping individual residents access needed care,
42 the program is also available as a resource for crisis management and promoting well-being among
43 trainees.

44 THE WORK OF THE AMA

45
46
47 The AMA has a number of policies on this topic, as noted in the Appendix to this report:

- 48 1. H-95.955, “Physician Impairment”
- 49 2. H-225.961, “Medical Staff Development Plans”
- 50

- 1 3. H-225.966, “Medical Staff Role in the Development of Substance Abuse Policies and
- 2 Procedures”
- 3 4. H-235.977, “Medical Staff Committees to Assist Impaired or Distressed Physicians”
- 4 5. H-295.872, “Expansion of Student Health Services”
- 5 6. H-295.955, “Teacher-Learner Relationship in Medical Education”
- 6 7. H-295.999, “Medical Student Support Groups”
- 7 8. H-310.907, “AMA Duty Hours Policy”
- 8 9. H-310.912, “Residents and Fellows’ Bill of Rights”
- 9 10. H-310.979, “Resident Physician Working Hours and Supervision”
- 10 11. H-345.973, “Mental Health Services for Medical Students and Resident and Fellow
- 11 Physicians”
- 12 12. H-345.981, “Access to Mental Health Services”
- 13 13. H-405.961, “Physician Health Programs”
- 14 14. D-405.990, Educating Physicians about Physician Health Programs”
- 15 15. D-405.992, “Physician Health and Wellness”
- 16 16. D-405.996, “Physician Well-Being and Renewal”
- 17 17. H-440.905, “Confidentiality, Counseling and Treatment in the Tuberculosis Screening of
- 18 Health Care Workers”
- 19 18. E-9.0305, “Physician Health and Wellness”
- 20 19. E-8.191, “Peers as Patients”

21
22 Included in the recommendations of this report are several items to consolidate existing AMA
23 policy on this topic. For example, a portion of AMA Policy H-345.973, “Mental Health Services
24 for Medical Students and Resident and Fellow Physicians,” is proposed for rescission, as it is
25 already reflected in LCME element 12.4, Student Access to Health Care Services (part of LCME
26 standard 12, Medical Student Health Services, Personal Counseling, and Financial Aid Services),
27 which reads: “A medical school provides its medical students with timely access to needed
28 diagnostic, preventive, and therapeutic health services at sites in reasonable proximity to the
29 locations of their required educational experiences and has policies and procedures in place that
30 permit students to be excused from these experiences to seek needed care.”

31
32 Aside from policy, the AMA has several ongoing projects/initiatives that address many aspects of
33 medical student and physician health. One example is the biennial International Conference on
34 Physician Health, a collaborative effort of the AMA, Canadian Medical Association, and British
35 Medical Association. The theme for the 2016 conference was “Increasing Joy in Medicine,” with a
36 focus on research about and perspectives into physicians’ health.

37
38 Similarly, the work of AMA member sections, including the Resident and Fellow Section, Young
39 Physicians Section, Organized Medical Staff Section, and others often touches on issues of
40 wellness, burnout, and physician health.

41
42 The AMA Academic Physicians Section (APS), for example, featured wellness/burnout throughout
43 the medical education and practice continuum as its educational focus during the 2016 Annual
44 Meeting. In his talk, Tait Shanafelt, MD, director of the Mayo Clinic Department of Medicine
45 Program on Physician Well-being at the Mayo School of Medicine in Rochester, Minn., reviewed
46 the literature on physician satisfaction and burnout and discussed the personal and professional
47 repercussions of physician distress. He also reviewed the individual and organizational approaches
48 to promoting physician well-being. Next, an interactive, hands-on session provided the opportunity
49 for medical education leaders to learn how creative expression—designing and constructing a mask
50 and drawing a comic—can mitigate the impacts of an unhealthy emotional environment, which can

1 lead to burnout. A third session on burnout was co-sponsored by the APS and the AMA Senior
2 Physicians Section, featuring Richard Gunderman, MD, a professor at Indiana University.

3
4 *AMA Medical Student Section*

5
6 Another AMA section that is addressing wellness/burnout is the AMA Medical Student Section.
7 The AMA-MSS works to represent the interests of medical students, improve medical education,
8 develop leadership, and promote activism for the health of America. Related to improving
9 accessibility to confidential health care services, the MSS can work to publicize, disseminate, and
10 advocate for all efforts undertaken by the AMA on this topic. As reflected in MSS policy on this
11 topic, some concrete recommendations for action at the medical school level include:

- 12
13 1. Creating a mental health awareness and suicide prevention screening program that would
14 be available to all medical students on an opt-out basis; ensure anonymity, confidentiality,
15 and protection from administration; provide proactive intervention for identified at-risk
16 students by mental health professionals; and educate students and faculty about personal
17 mental health and factors that may contribute to suicidal ideation.
18
19 2. Increasing or enhancing existing collaborations between university mental health
20 specialists and local health centers to provide a larger pool of mental health resources.
21
22 3. Basing actions to improve access to confidential health services for medical students (e.g.,
23 on-campus programs, local campaigns) on the concepts of accessibility and de-
24 stigmatization.
25

26 *Accelerating Change in Medical Education*

27
28 The AMA's Accelerating Change in Medical Education consortium comprises 32 medical schools
29 working together to create the medical school of the future and transform physician training. An
30 estimated 19,000 medical students—18% of all U.S. allopathic and osteopathic medical students—
31 study at medical schools that are consortium members. The projects of several member schools of
32 the consortium are focused on medical student wellness, including Eastern Virginia Medical
33 School and Mayo Medical School. Further, the consortium has a newly formed student wellness
34 interest group to share ideas across schools as to best practices to ensure wellness and counter
35 burnout. Finally, several submissions to the 2015 AMA Medical Education Innovation Challenge
36 focused on medical student wellness, including the third place winner, submitted by a team from
37 the University of Louisville School of Medicine.
38

39 *Professional Satisfaction and Practice Sustainability, Steps Forward modules*

40
41 As one of the AMA's three key strategic focus areas, the Professional Satisfaction and Practice
42 Sustainability initiative is addressing issues that practicing physicians face, including concerns with
43 electronic health records and the rising wave of documentation requirements from insurers and
44 regulators, by providing useful and user-friendly tools and apps to help ease the burdens of the
45 administrative side of medicine. Indeed, for many physicians, dealing with regulatory, certification,
46 licensure, insurer, and other rules and dictates represent a challenging and unfulfilling aspect of
47 medicine. It is not surprising, then, that data from the AMA's Steps Forward website show that the
48 Preventing Physician Burnout module is among the most popular modules that have been accessed
49 via the site.

1 *AMA Council on Ethical and Judicial Affairs (CEJA)*

2
3 The AMA Council on Ethical and Judicial Affairs (CEJA) works to maintain and update the *Code*
4 *of Medical Ethics*, through its policy development function, and to promote adherence to the
5 professional ethical standards set out in the *Code*, through its judicial function. Related to the topic
6 of this report, CEJA may wish to review its guidance so that AMA ethics policy addresses conflicts
7 of interest involving confidential health services for medical students and resident/fellow
8 physicians, in addition to that of physicians.

9
10 THE WORK OF PROFESSIONAL ASSOCIATIONS AND OTHER ENTITIES

11
12 Other entities involved in this issue include the Association of American Medical Colleges and
13 American Osteopathic Association. In addition, through its role in identifying major issues in
14 education and focusing national attention on these issues, the U.S. Department of Education should
15 be a major stakeholder in any kind of education reform (e.g., de-stigmatization of mental health
16 services). The Department's role might include allocating funds to research on this topic, releasing
17 data on what successful de-stigmatization efforts would entail (and encouraging states to
18 implement those efforts), and, more generally, informing the public on the importance of access to
19 mental health services in post-secondary education.

20
21 *Federation of State Medical Boards (FSMB) and State Medical Boards*

22
23 Physician burnout is a key topic of interest for the Federation of State Medical Boards (FSMB).
24 Currently, an FSMB workgroup, appointed by FSMB chair Art Hengerer, MD is studying burnout
25 on behalf of the nation's state medical and osteopathic boards. In addition, the FSMB participated
26 in a planning meeting in July at the National Academy of Medicine—at the invitation of its
27 president, Victor Dzau, MD—to explore the issue of physician burnout and the role of the National
28 Academies of Sciences, Engineering and Medicine in advancing a solution. The meeting was co-
29 hosted by Darrell Kirch, MD, CEO of the Association of American Medical Colleges, and Tom
30 Nasca, MD, CEO of the Accreditation Council for Graduate Medical Education.

31
32 Meanwhile, the state medical licensing boards can work to de-stigmatize treatment for mental
33 illness. In this regard, the FSMB and the state boards should consider a reevaluation of the scope of
34 boards' access to applicants' health records during the medical licensure application process,
35 including the need for applicants to disclose treatment received by a mental health professional.
36 This disclosure may have a chilling effect on medical students who would like to seek treatment for
37 their mental illness; students may fear being perceived as professionally impaired and/or
38 discriminated against by medical boards.

39
40 One example, from the Illinois Application for Physician Licensure, Question 4 of Personal
41 History,¹¹ is illustrative of the scope of licensing boards' queries related to mental health; it asks
42 for:

43
44 A report from any and all physicians, counselors, or therapists from whom you have received
45 treatment for any chronic disease or condition (i.e., chemical/ alcohol dependency, depression,
46 etc.). The report must include dates of treatment, method of treatment, diagnosis, and
47 prognosis. Attach a detailed statement advising whether you are currently under treatment. If
48 you have been treated as an inpatient/outpatient at any time for any disease or condition, then it
49 will be necessary for you to have the institution(s) submit, directly to this Department, copies
50 of any and all admitting histories, physicals and discharge summaries for each
51 inpatient/outpatient stay or treatment.

1 Similarly, state boards of professional regulation, in their work to ensure patient protection, may
2 consider a less punitive approach to addressing physician impairment. For example, boards could
3 reevaluate the factors that contribute to the suspension of a medical license and determine whether
4 these factors: (a) relate to mental illness; and (b) could be replaced with an option for treatment,
5 rather than or in addition to a punishment (i.e., license suspension).
6

7 *Physician Health Programs*

8

9 Related to state physician health programs, one potential model/best practice comes from
10 Colorado, where the Colorado Physician Health Program (CPHP) offers a safe haven for reporting
11 of physicians with mental health issues to the medical board.¹² That is, physicians who are applying
12 or reapplying for a Colorado medical license can ensure, under specific conditions, that certain
13 medical and/or psychiatric matters will remain unknown to the state medical board.
14

15 As with other state medical board licensure applications, the Colorado application includes
16 questions pertaining to medical/psychiatric health, encompassing substance use, mental health
17 disorders, and cognitive matters. The applicant must indicate either yes or no, to acknowledge or
18 deny the presence of a medical or psychiatric condition, respectively.
19

20 The applicant may also answer no, and keep certain personal health matters unknown to the
21 medical board, if: 1) the CPHP has been informed of the applicant's health matter(s); 2) the
22 applicant has attended an initial appointment with CPHP for the behavior or condition; and 3) there
23 is compliance with all of CPHP's requirements for evaluation, treatment, and/or monitoring.
24

25 This safe haven encourages physicians to proactively seek and receive the health care services they
26 need, confidentially, and provides assurance to the Colorado medical board (through oversight by
27 the CPHP) that patient safety is not jeopardized.
28

29 SUMMARY AND RECOMMENDATIONS

30

31 Ensuring access to confidential health services for medical students and physicians offers many
32 ethical, logistical, educational, and systemic/cultural challenges. Fortunately, a variety of
33 programs/initiatives/requirements are currently in place, from accrediting agencies and medical
34 institutions, along with the AMA and other professional associations, to ensure more attention and
35 holistic solutions to this issue. The Council on Medical Education believes that this report and its
36 recommendations will help raise awareness of and action on this important issue as it relates to the
37 medical education needs of medical students and physicians throughout the continuum.
38

39 The Council on Medical Education therefore recommends that the following recommendations be
40 adopted in lieu of Resolutions 901-I-15, 913-I-15, and 304-A-16, and the remainder of the report
41 be filed.
42

- 43 1. That our American Medical Association (AMA) ask the Liaison Committee on Medical
44 Education, Commission on Osteopathic College Accreditation, American Osteopathic
45 Association, and Accreditation Council for Graduate Medical Education to encourage
46 medical schools and residency/fellowship programs, respectively, to:
47

- 48 1) Provide or facilitate the immediate availability of urgent and emergent access to low-
49 cost, confidential health care and mental health counseling services that: a) include
50 appropriate follow-up; b) are outside the trainees' grading and evaluation pathways; and c)
51 are available (based on patient preference and need for assurance of confidentiality) in

1 reasonable proximity to the education/training site, at an external site, or through
2 telemedicine or other virtual, online means;

3
4 2) Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as
5 these regulations exist in part to ensure the mental and physical health of trainees;

6
7 3) Encourage and promote routine health screening among medical students and
8 resident/fellow physicians, and consider designating some segment of already-allocated
9 personal time off (if necessary, during scheduled work hours) specifically for routine
10 health screening and preventive services, including physical, mental, and dental care; and
11

12 4) Remind trainees and practicing physicians to avail themselves of any needed resources,
13 both within and external to their institution, to provide for their mental and physical health
14 and well-being, as a component of their professional obligation to ensure their own fitness
15 for duty and the need to prioritize patient safety and quality of care by ensuring appropriate
16 self-care, not working when sick, and following generally accepted guidelines for a healthy
17 lifestyle. (New HOD Policy).

18
19 2. That our AMA urge state medical boards to accept “safe haven” non-reporting for
20 physicians seeking licensure or relicensure who are undergoing treatment for mental health
21 issues, to help ensure confidentiality of such treatment for the individual physician while
22 providing assurance of patient safety. (New HOD Policy).

23
24 3. That Policy H-345.973, “Mental Health Services for Medical Students and Resident and
25 Fellow Physicians,” be amended by addition and deletion, as follows.

26
27 Medical and Mental Health Services for Medical Students and Resident and Fellow
28 Physicians

29
30 Our AMA promotes the availability of timely, confidential, accessible, and
31 affordable medical and mental health services for medical students and resident and fellow
32 physicians, to include needed diagnostic, preventive, and therapeutic services. Information
33 on where and how to access these services should be readily available at all
34 education/training sites, and these services should be provided at sites in reasonable
35 proximity to the sites where the education/training takes place. (Modify Current HOD
36 Policy).

37
38 4. That Policy H-295.872, “Expansion of Student Health Services,” be rescinded, as it is (in
39 part) already reflected in current LCME standards and (in part) now incorporated into
40 Policy H-345.973, Mental Health Services for Medical Students and Resident and Fellow
41 Physicians. (Rescind HOD Policy).

42
43 5. That Policy D-405.992, “Physician Health and Wellness,” and D-405.996, “Physician
44 Well-Being and Renewal,” be rescinded, as these directives have been accomplished, are
45 superseded by other policy, or are no longer relevant. (Rescind HOD Policy).

46
47 6. That Policy D-405.983, “Medical Students and Residents as Patients,” be rescinded, as
48 having been fulfilled by this report. (Rescind HOD Policy).

Fiscal Note: \$1,000.

APPENDIX: RELEVANT AMA POLICY

H-95.955, “Physician Impairment”

(1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of impairment problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician impairment, particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.

H-225.961, “Medical Staff Development Plans”

1. All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care.

H-225.966, “Medical Staff Role in the Development of Substance Abuse Policies and Procedures”

1. Our AMA establishes the primacy of medical staff authority in substance abuse policy and procedures covering any pre-employment, credentialing, or other phases of physician evaluation. 2. Policy of the AMA states that medical staff must be involved in the development of the institution’s substance abuse policy, including: (a) selection of analytical methods to ensure scientific validity of the test results, (b) determination of measures to maintain confidentiality of the test results, (c) in for-cause post-incident/injury testing, definition of standards for determining whether cause exists and which incidents and/or injuries will result in testing, and (d) development of mechanisms to address the physical and mental health of medical staff members. 3. The AMA believes all drug and alcohol testing must be performed only with substantive and procedural due process safeguards in place.

H-235.977, “Medical Staff Committees to Assist Impaired or Distressed Physicians”

Our AMA recognizes the importance of early recognition of impaired or distressed physicians, and encourages hospital medical staffs to have provisions in their bylaws for a mechanism to address the physical and mental health of their medical staff and housestaff members.

H-295.872, “Expansion of Student Health Services”

1. It is AMA policy that medical students should have timely access to needed preventive and therapeutic medical and mental health services at sites in reasonable proximity to where their education is occurring. 2. Out AMA will encourage the LCME to develop an annotation to its standard on medical student access to preventive and therapeutic health services that includes a specification of the following: a. Medical students should have timely access to needed preventive and therapeutic medical and mental health services at sites in reasonable proximity to where their education is occurring. b. Medical students should have information about where and how to access health services at all locations where training occurs. c. Medical schools should have policies that permit students to be excused from class or clinical activities to seek needed care.

H-295.955, “Teacher-Learner Relationship in Medical Education”

CODE OF BEHAVIOR: The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct... Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students, which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual’s work; intentional neglect or intentional lack of communication...

H-295.999, “Medical Student Support Groups”

(1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty.(2) Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

H-310.907, “AMA Duty Hours Policy”

Our AMA adopts the following Principles of Resident/Fellow Duty Hours, Patient Safety, and Quality of Physician Training: 3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of duty hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.

H-310.912, “Residents and Fellows’ Bill of Rights”

...E. Adequate compensation and benefits that provide for resident well-being and health. (3) With Regard to Benefits, Residents and Fellows Should Receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care; b. Education on the signs of excessive fatigue, clinical depression, and substance abuse and dependence; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, maternity and paternity leave and educational leave during each year in their training program the total amount of which should not be less than six weeks; and e. Leave in compliance with the Family and Medical Leave Act.

H-310.979, “Resident Physician Working Hours and Supervision”

(1) Our AMA supports the following principles regarding the supervision of residents and the avoidance of the harmful effects of excessive fatigue and stress: (g) The program director, with institutional support, must assure for each resident effective counseling as stated in Section II.D.4.k of the Institutional requirements: "Counseling services: The Sponsoring Institution should facilitate residents' access to confidential counseling, medical, and psychological support services."

H-345.973, “Mental Health Services for Medical Students and Resident and Fellow Physicians”

Our AMA promotes confidential, accessible, and affordable mental health services for medical students and resident and fellow physicians.

H-345.981, “Access to Mental Health Services”

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness: (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public; (2) improving public awareness of effective treatment for mental illness; (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents; (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity; (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and (6) reducing financial barriers to treatment.

H-405.961, “Physician Health Programs”

Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.

D-405.990, “Educating Physicians about Physician Health Programs”

1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; and 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training.

D-405.992, “Physician Health and Wellness”

Our AMA: (1) supports programs related to physician health and wellness, including those offered in conjunction with the Federation of State Physician Health Programs; (2) will convene those interested in medical education in an effort to bring the dialogue about healthy lifestyle and balance early in the careers of medical students and residents; and (3) considers the concept of physician wellness as an element of the AMA Strategic Plan.

D-405.996, “Physician Well-Being and Renewal”

Our AMA will work with the Federation of State Physician Health Programs to establish and promulgate a networking resource/database and web site clearinghouse for Medical Staff Physician Health Committees or their equivalents in physician groups throughout the country, and to provide resources that will allow such committees to proactively initiate programs of wellness and illness prevention for physicians.

H-440.905, “Confidentiality, Counseling and Treatment in the Tuberculosis Screening of Health Care Workers”

The AMA encourages all health care organizations that require Tuberculosis screening tests to adopt standards which guarantee health care workers and medical students the right to confidentiality, appropriate counseling, and treatment following the positive results of a tuberculosis skin test; and encourages all health care organizations that require Tuberculosis screening tests to adopt standards which guarantee prospective health care workers and volunteers confidentiality and education about treatment options following the positive results of a tuberculosis skin test.

9.3.1, “Physician Health & Wellness”

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

AMA Principles of Medical Ethics: I,II,IV

10.3, “Peers as Patients”

The opportunity to care for a fellow physician is a privilege or physician-in-training and may represent a gratifying experience and serve as a show of respect or competence. However, physicians must recognize that providing medical care for a fellow professional can pose special challenges for objectivity, open exchange of information, privacy and confidentiality, and informed consent.

In emergencies or isolated rural settings when options for care by other physicians are limited or where there is no other qualified physician available, physicians should not hesitate to treat colleagues.

Physicians must make the same fundamental ethical commitments when treating peers as when treating any other patient. Physicians who provide medical care to a colleague should:

- (a) Exercise objective professional judgment and make unbiased treatment recommendations despite the personal or professional relationship they may have with the patient.
- (b) Be sensitive to the potential psychological discomfort of the physician-patient, especially when eliciting sensitive information or conducting an intimate examination.
- (c) Respect the physical and informational privacy of physician-patients. Discuss how to respond to inquiries about the physician-patient’s medical care from colleagues. Recognize that special measures may be needed to ensure privacy.
- (d) Provide information to enable the physician-patient to make voluntary, well-informed decisions about care. The treating physician should not assume that the physician-patient is knowledgeable about his or her medical condition.

Physicians-in-training and medical students (when they provide care as part of their supervised training) face unique challenges when asked to provide or participate in care for peers, given the circumstances of their roles in residency programs and medical schools. Except in emergency situations or when other care is not available, physicians-in-training should not be required to provide medical care for fellow trainees, faculty members, or attending physicians if they are reluctant to do so.

AMA Principles of Medical Ethics: VI

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-16)

Introduced by: Resident and Fellow Section

Subject: Expanding the Treatment of Opiate Dependence Using Medication-Assisted Treatment by Physicians in Residency Training Programs

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

1 Whereas, The Centers for Disease Control and Prevention recently announced that death due
2 to drug overdose has reached an unprecedented 14.7 per 100,000 in 2014 (45,000 people in
3 US), with 61% of deaths involving some form of opioid;¹ and
4
5 Whereas, Buprenorphine and naloxone (suboxone) are effective components of the medication-
6 assisted treatment of opioid use disorders which have a favorable safety and tolerability profile
7 in numerous populations;² and
8
9 Whereas, The Department of Health and Human Services has recently announced a new rule,
10 which expands the patient limit for qualified physicians to treat opioid use disorders using
11 buprenorphine in order to increase access to medication-assisted treatment for opioid abuse
12 and dependence;³ and
13
14 Whereas, The 2014 Buprenorphine Summit held by the Substance Abuse and Mental Health
15 Services Administration (SAMHSA) and the National Institute on Drug Abuse (NIDA) notes that
16 increasing resident exposure to medication-assisted treatment for addiction is a strategy to
17 improve patient access to the medication;⁴ and
18
19 Whereas, The Drug Addiction Treatment Act of 2000 allows for a physician in a residency
20 training program with an unrestricted license and the appropriate Drug Enforcement
21 Administration registration to receive a waiver to prescribe buprenorphine, provided it is in
22 accordance with state laws regarding the use of Schedule III narcotics for detoxification and
23 maintenance therapy;⁵ and
24
25 Whereas, Addiction clinics in which residents prescribe buprenorphine are prevalent but barriers
26 to resident prescription of the medication remain, including funding for buprenorphine waiver
27 training, supervision and patient continuity from a certified addiction medicine physician, as well
28 as support staff for scheduling, billing and urine drug testing;^{6,7,8} therefore be it

¹ US drug overdose deaths: a global challenge. *Lancet*. 2016;387(10017):404.

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- 1 RESOLVED, That our American Medical Association encourage the expansion of residency and
2 fellowship training opportunities to provide clinical experience in the medication-assisted
3 treatment of opioid use disorders, under the supervision of an appropriately trained physician
4 (New HOD Policy); and be it further
5
6 RESOLVED, That our AMA support additional funding to overcome the financial barriers that
7 exist for trainees seeking clinical experience in the medication-assisted treatment of opioid use
8 disorders. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/12/16

RELEVANT AMA POLICY

Methadone Maintenance in Private Practice H-95.957

Our AMA: (1) reaffirms its position that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further; (2) supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens but further research is needed; (3) encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users; (4) supports modification of federal and state laws and regulations to make newly approved anti-addiction medications available to those office-based physicians who are appropriately trained and qualified to treat opiate withdrawal and opiate dependence in accordance with documented clinical indications and consistent with sound medical practice guidelines and protocols; and (5) urges that guidelines and protocols for the use of newly approved anti-addiction medications be developed jointly by appropriate national medical specialty societies in association with relevant federal agencies and that continuing medical education courses on opiate addiction treatment be developed by these specialty societies to help designate those physicians who have the requisite training and qualifications to provide therapy within the broad context of comprehensive addiction treatment and management. (CSA Rep. 2, I-94; Reaffirmed: CSA Rep. 12 and Append Res. 412, A-99; Reaffirmation I-00; Modified: CSAPH Rep. 1, A-10)

Prevention of Opioid Overdose D-95.987

1. Our AMA: (A) recognizes the great burden that opioid addiction and prescription drug abuse places on patients and society alike and reaffirms its support for the compassionate treatment of such patients; (B) urges that community-based programs offering naloxone and other opioid overdose prevention services continue to be implemented in order to further develop best practices in this area; and (C) encourages the education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities; and (D) will continue to monitor the progress of such initiatives and respond as appropriate.

2. Our AMA will: (A) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose; and (B) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for opioid overdose. (Res. 526, A-06; Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16)

Third Party Payer Quantity Limits H-185.942

1. Our AMA supports the protection of the patient-physician relationship from interference by payers via various utilization control mechanisms, including medication and testing and treatment supply quantity limits.
2. Our AMA will work with third party payers to ensure that if they use quantity limits for prescription drugs or testing and treatment supplies, an exceptions process must be in place to ensure that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, and that any such process should place a minimum burden upon patients, physicians and their staff.
3. Our AMA supports interested state legislative efforts and federal action and will develop model state legislation to ensure that third party payers that institute quantity limits for prescription drugs or testing and treatment supplies include an exceptions process so that patients can access higher or lower quantities of prescription drugs or testing and treatment supplies if medically necessary, including provisions such as the following:
 - physicians can specify limited supplies of medications during initial trials of a medication, or if a larger quantity of medication would expose an at-risk patient to potential harm (e.g., opioids, benzodiazepines, or psychostimulants)- physicians can appeal adverse determinations regarding quantity limitations;- payers must provide an easily accessible list of all medications and testing and treatment supplies with quantity limits and the requirements for the exception process on the payer's Web site;- payers must indicate, what, if any, clinical criteria (e.g., evidence-based guidelines, FDA label, scientific literature) support the plan's quantity limitations;- physicians with specialized qualifications may not be subject to quantity limits;- payers cannot charge patients for an additional co-pay if an exception request for a higher medication or testing and treatment supply quantity has been approved based on medical necessity;- payer decisions on exception, and subsequent appeal requests, of quantity limits must be made within two working days in nonurgent situations and one working day in urgent cases; and- physicians or patients can submit any denied appeals to an independent review body for a final, binding decision. (BOT Rep. 12, A-12)

Protection for Physicians Who Prescribe Pain Medication H-120.960

Our AMA supports the following:

- (1) the position that physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution. It is the policy of the AMA that state medical societies and boards of medicine develop or adopt mutually acceptable guidelines protecting physicians who appropriately prescribe and/or administer controlled substances to relieve intractable pain before seeking the implementation of legislation to provide that protection;
- (2) education of medical students and physicians to recognize addictive disorders in patients, minimize diversion of opioid preparations, and appropriately treat or refer patients with such disorders; and
- (3) the prevention and treatment of pain disorders through aggressive and appropriate means, including the continued education of doctors in the use of opioid preparations.

Our AMA opposes harassment of physicians by agents of the Drug Enforcement Administration in response to the appropriate prescribing of controlled substances for pain management. (BOT Rep. 1, I-97; Reaffirm: Res. 237, A-99; Appended: Res. 506, A-01; Appended: Sub. Res. 213, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmed: BOT Rep. 3, I-13; Reaffirmation A-15)

Opioid Treatment and Prescription Drug Monitoring Programs D-95.980

Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs. (BOT Rep. 11, A-10)

Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985

1. Our AMA will incorporate into its web site a directory consolidating available information on the safe and effective use of opioid analgesics in clinical practice.
2. Our AMA, in collaboration with Federation partners, will collate and disseminate available educational and training resources on the use of methadone for pain management. (Sub. Res. 508, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Append: Res. 515, A-14; Reaffirmed: BOT Rep. 14, A-15)

Drug Abuse Related to Prescribing Practices H-95.990

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:

A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.

B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:

A. promotes physician training and competence on the proper use of controlled substances;

B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;

C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and

D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.

4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances. (CSA Rep. C, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 907, I-11; Appended: Res. 219, A-12; Reaffirmation A-15; Reaffirmed: BOT Rep. 12, A-15; Reaffirmed: BOT Rep. 5, I-15)

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999

Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states. (CSA Rep. 12, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(I-16)

Introduced by: Resident and Fellow Section

Subject: Protecting the Rights of Breastfeeding Resident and Fellows

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

- 1 Whereas, Many female medical students, residents and fellows are of childbearing age, with
2 many having children during medical school, residency or fellowship; and
3
4 Whereas, Many hospital and clinical work environments do not support protected times or
5 places in which medical students, residents or fellows may express breast milk or safely store
6 pumped milk; and
7
8 Whereas, The medical benefits of breast milk have been widely studied and supported by
9 physicians and researchers; and
10
11 Whereas, Studies have demonstrated that a majority of physician mothers want to exclusively
12 breastfeed for up to 12 months, but many were unable to do so due to work-related factors that
13 influence physician mothers' breastfeeding behavior; and
14
15 Whereas, The Fair Labor Standards Act of 1938 was amended with Section 4207 to require an
16 employer to provide reasonable break time for an employee to express breast milk for her
17 nursing child for one year after the child's birth, at each time such employee has need to
18 express milk; and
19
20 Whereas, Our AMA, in policy H-245.982, "encourages all medical schools and graduate medical
21 education programs to support all residents, medical students and faculty who provide breast
22 milk for their infants, including appropriate time and facilities to express and store breast milk
23 during the working day;" and
24
25 Whereas, Section VI "Resident Duty Hours in the Learning and Working Environment"
26 of Accreditation Council for Graduate Medical Education Common Program Requirements for
27 July 2016 does not include any protective provisions for breast expression for residents or
28 fellows; therefore be it
29
30 RESOLVED, That our American Medical Association work with appropriate bodies, such as the
31 Accreditation Council for Graduate Medical Education (ACGME), to mandate language in
32 housestaff manuals or similar policy references of all training programs on the protected time
33 and locations for milk expression and storage of breast milk (Directive to Take Action); and be it
34 further
35
36 RESOLVED, That our AMA work with appropriate bodies, such as the ACGME and the
37 Association of American Medical Colleges, to include language related to the learning and work
38 environments for breast feeding mothers in regular program reviews. (Directive to Take Action)

References:

<http://pediatrics.aappublications.org/content/131/2/387>

<http://online.liebertpub.com/doi/abs/10.1089/bfm.2009.0090>

<https://www.change.org/p/accreditation-council-for-graduate-medical-education-request-the-acgme-to-develop-standard-maternity-leave-and-nursing-break-policies>

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/12/16

RELEVANT AMA POLICY

AMA Support for Breastfeeding H-245.982

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottlefeeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum

period. (CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation, A-07; Reaffirmation, A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16)

Breast Milk Banking H-245.972

Our AMA encourages breast milk banking. (Res. 443, A-07)

Lodging, Meeting Venues, and Social Functions G-630.140

AMA policy on lodging and accommodations includes the following: (1) Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors. (2) Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity. (3) All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy. (4) It is the policy of our AMA not to hold meetings or pay member, officer or employee dues in any club, restaurant, or other institution that has exclusionary policies based on gender, race, color, religion, national origin, gender identity, or sexual orientation. (5) Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping. (Res. 2, I-87; Reaffirmed: Sunset Report, I-97; Res. 512, I-98; Consolidated: CLRPD Rep. 3, I-01; Reaffirmation A-04; Modified CCB/CLRPD Rep. 3, A-12; Modified: CCB/CLRPD Rep. 2, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-16)

Introduced by: Resident and Fellow Section

Subject: Primary Care and Mental Health Training in Residency

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

-
- 1 Whereas, 50% of primary care visits involve concerns about behavioral health comorbidities and
2 60% of mental illness is treated by primary care providers;¹ and
3
4 Whereas, Child and adolescent psychiatry is one of the most underserved medical
5 subspecialties;² and
6
7 Whereas, Primary care physicians often feel unprepared to manage patients with complex
8 psychiatric comorbidities;³ and
9
10 Whereas, Internal medicine, family medicine, and pediatric residents do not receive
11 collaborative psychiatric supervision during their residency, nor do psychiatry residents and
12 fellows receive training in how to liaise with primary care offices; and
13
14 Whereas, Our AMA has policy which encourages practicing physicians to seek out continuing
15 medical education opportunities on integrated physical and behavioral health care and promotes
16 the development of sustainable payment models that would be used to fund the necessary
17 services inherent in integrating behavioral health care services into primary care settings (AMA
18 Policy H-385.915); therefore be it
19
20 RESOLVED, That our American Medical Association advocate for the incorporation of
21 integrated mental health and primary care services into existing psychiatry and primary care
22 training programs' clinical settings (New HOD Policy); and be it further
23
24 RESOLVED, That our AMA encourage primary care and psychiatry residency training programs
25 to create and expand opportunities for residents to obtain clinical experience working in an
26 integrated mental health and primary care model, such as the collaborative care model (New
27 HOD Policy); and be it further
28
29 RESOLVED, That our AMA advocate for appropriate reimbursement to support the practice of
30 integrated physical and mental health care in clinical care settings. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/12/16

¹ Pirl W.F., Beck B.J., Safren, S. A., Kim H (2001). "A descriptive study of psychiatric consultations in a community primary care center". Primary Care Companion Journal of Clinical Psychiatry 3 (5): 190–194. doi:10.4088/PCC.v03n0501.

² Simpson G.A., Bloom B., Cohen R.A., et al. U.S. children with emotional and behavioral difficulties: Data from the 2001, 2002, and 2003 National Health Interview Surveys. Adv Data 2005; 23: 1–13.

³ Loeb D.F., Bayliss E.A., Binswanger I.A., et al. (2012). "Primary care physician perceptions on caring for complex patients with medical and mental illness". Journal of General Internal Medicine. 2012 Aug; 27 (8):945-52. doi: 10.1007/s11606-012-2005-9

RELEVANT AMA POLICY

Integrating Physical and Behavioral Health Care H-385.915

Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings. (CMS Rep. 6, A-15)

Prevention of Unnecessary Hospitalization and Jail Confinement of the Mentally Ill H-345.995

Our AMA urges physicians to become more involved in pre-crisis intervention, treatment and integration of chronic mentally ill patients into the community in order to prevent unnecessary hospitalization or jail confinement. (Res. 16, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmation, A-15)

Access to Mental Health Services D-345.997

Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment for mental illness; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process. (CMS Rep. 9, A-01; Reaffirmed: CMS Rep., A-11; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of res. 808, I-14)

Mental Health Crisis Interventions H-345.972

Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; and (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs. (Res. 923, I-15)

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984

Awareness, Diagnosis and Treatment of Depression and Other Mental Illnesses: (1) Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings. (2) Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase

patient access to quality care for depression and other mental illnesses. (Res. 502, I-96; Reaffirm & Append: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12)

Access to Mental Health Services H-345.981

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:

- (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
- (2) improving public awareness of effective treatment for mental illness;
- (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
- (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
- (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
- (6) reducing financial barriers to treatment. (CMS Rep. 9, A-01; Reaffirmation, A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14)

Statement of Principles on Mental Health H-345.999

- (1) Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed, but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat mental illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive.
- (2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health program.
- (3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.
- (4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field. (A-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

Increasing Detection of Mental Illness and Encouraging Education D-345.994

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.
2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment. (Res. 412, A-06; Appended: Res. 907, I-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-16)

Introduced by: Resident and Fellow Section
Subject: Improving Access to Care and Health Outcomes
Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

1 Whereas, The U.S has higher prevalence of chronic diseases compared to other nations with
2 poorer health outcomes, large disparities with varying access and utilization of health care
3 services across populations;¹ and
4
5 Whereas, Chronic diseases are the leading cause of mortality and morbidity as well as high cost
6 of care in the U.S.;¹ and
7
8 Whereas, The American Public Health Association defines a community health worker (CHW)
9 as “a frontline public health worker who is a trusted member of and/or has an unusually close
10 understanding of the community served. This trusting relationship enables the worker to serve
11 as a liaison/link/intermediary between health/social services and the community to facilitate
12 access to services and improve the quality and cultural competence of service delivery. A CHW
13 also builds individual and community capacity by increasing health knowledge and self-
14 sufficiency through a range of activities such as outreach, community education, informal
15 counseling, social support and advocacy”;² and
16
17 Whereas, CHWs are effective in promoting health and improving health outcomes in their
18 communities;^{3,4} and
19
20 Whereas, CHWs are community builders that are culturally competent^{2,3,4} at understanding the
21 socioeconomic challenges of the community they work in; and
22
23 Whereas, CHWs deliver cost benefit caring for chronic diseases;^{3,4} therefore be it
24
25 RESOLVED, That our American Medical Association support training opportunities for students
26 and residents to learn cultural competency from community health workers. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/12/16

¹ US Department of Health and Human Services. *Chronic diseases: The leading causes of death.*

² Brown 3rd H, Wilson KJ, Pagán JA, et al. Cost-effectiveness analysis of a community health worker intervention for low-income hispanic adults with diabetes. *Prev Chronic Dis.* 2012;9:E140.

³ Ryabov I. Cost-effectiveness of community health workers in controlling diabetes epidemic on the US–Mexico border. *Public Health.* 2014;128(7):636-642.

⁴ Alvillar M, Quinlan J, Rush CH, Dudley DJ. Recommendations for developing and sustaining community health workers. *J Health Care Poor Underserved.* 2011;22(3):745-750.

RELEVANT AMA POLICY

Incorporating Community Health Workers into the US Health Care System H-440.828

1. Our AMA encourages states and other appropriate stakeholders to establish that community health workers work under a strict protocol for any activity that relates to clinical matters and that this protocol be developed by the physician-led health care team.
2. Our AMA encourages states and other appropriate stakeholders to conduct background checks on community health workers prior to the community health worker providing services and take the background check results into appropriate consideration.
3. Our AMA encourages states and other appropriate stakeholders to develop a set of defined core competencies and skills of community health workers.
4. Our AMA encourages states to support or establish the training, certification, and continuing education of community health workers that allow for multiple points of entry into the profession.
5. Our AMA encourages health insurers and other appropriate stakeholders to promote sustainable funding mechanisms such as public and private insurance to finance community health worker services and that this funding not be part of funds allocated for physician payment.
6. Our AMA encourages states and other appropriate stakeholders to engage in collaborative efforts with community health workers and their professional organizations in the development and implementation of policies related to community health workers.
7. Our AMA encourages states to consider privacy and liability issues related to the inclusion of community health workers in the physician-led health care team. (CMS Rep. 7, I-15)

Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982

AMA policy is that our AMA:

- (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;
- (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.
- (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;
- (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;
- (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;
- (6) urges states to administer their Medicaid and SCHIP programs through a single state agency;
- (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

- (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;
- (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;
- (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;
- (11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;
- (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
- (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
- (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
- (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
- (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
- (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
- (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
- (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations. (BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation, A-02; Modified: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6,

A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation, A-05; Reaffirmation, A-07; Modified: CMS Rep. 8, A-08; Reaffirmation, A-11; Modified: CMS Rep. 3, I-11)

Strategies to Increase Diabetes Awareness D-440.935

Our AMA will organize a series of activities for the public in collaboration with health care workers and community organizations to bring awareness to the severity of diabetes and measures to decrease its incidence. (Res. 412, A-13)

Patient Navigation Programs H-373.994

1. Our AMA recognizes the increasing use of patient navigator and patient advocacy services to help improve access to care and help patients manage complex aspects of the health care system. In order to ensure that patient navigator services enhance the delivery of high-quality patient care, our AMA supports the following guidelines for patient navigator programs:

- a) The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits, and responsibilities.
- b) Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team.
- c) Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions, or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of their medical care team.
- d) Patient navigators should fully disclose relevant training, experience, and credentials, in order to help patients understand the scope of services the navigator is qualified to provide.
- e) Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.

2. Our AMA will work with the American College of Surgeons and other entities and organizations to ensure that patient navigators are free of bias, do not have any role in directing referrals, do not usurp the physician's role in and responsibility for patient education or treatment planning, and act under the direction of the physician or physicians primarily responsible for each patient's care.

3. Policy provisions for patient navigators are also relevant for community health workers and other non-clinical public health workers. (CMS Rep. 7, I-11; Appended: CMS Rep. 7, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-16)

Introduced by: Resident and Fellow Section

Subject: Privacy, Personal Use and Funding of Mobile Devices

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

-
- 1 Whereas, The technological revolution of the past decades launched a wave of unprecedented
2 growth and portability in electronic and information technology; and
3
4 Whereas, Personal mobile devices, such as, netbooks, personal digital assistants, tablets,
5 phone-tablet hybrids (“phablets”), and smartphones, have become almost ubiquitous in any
6 workplace, including the healthcare environment; and
7
8 Whereas, Healthcare staffs use personal mobile devices for both personal and professional
9 reasons, ranging from sending emails and text messages to remotely accessing medical
10 records on Virtual Private Networks and virtual desktops, in an effort to improve
11 communications, clinical services, and patient care; and
12
13 Whereas, Specialty training programs, such as family medicine, radiology, general surgery, and
14 internal medicine, have used a variety of mobile devices to improve the learning process and
15 clinical training environment;^{1,2,3,4} and
16
17 Whereas, Studies have indicated that using medical apps on mobile devices has resulted in
18 improvement in learning for medical students, residents, and faculty;^{5,6,7} and
19
20 Whereas, Integration of mobile devices and mobile platforms has resulted in increased
21 connectedness among residents and attending, which led to more efficient care and safety
22 checks, as well as better real-time report of clinically significant events;⁶ and

¹ Archibald D, Macdonald CJ, Plante J, Hogue RJ, Fiallos J. Residents' and preceptors' perceptions of the use of the iPad for clinical teaching in a family medicine residency program. *BMC Med Educ.* 2014;14:174. doi:10.1186/1472-6920-14-174.

² Berkowitz SJ, Kung JW, Eisenberg RL, Donohoe K, Tsai LL, Slanetz PJ. Resident iPad use: has it really changed the game? *J Am Coll Radiol JACR.* 2014;11(2):180-184. doi:10.1016/j.jacr.2013.04.017.

³ Gandsas A, McIntire K, Montgomery K, Bumgardner C, Rice L. The personal digital assistant (PDA) as a tool for telementoring endoscopic procedures. *Stud Health Technol Inform.* 2004;98:99-103.

⁴ Patel BK, Chapman CG, Luo N, Woodruff JN, Arora VM. Impact of mobile tablet computers on internal medicine resident efficiency. *Arch Intern Med.* 2012;172(5):436-438. doi:10.1001/archinternmed.2012.45.

⁵ Boruff JT, Storie D. Mobile devices in medicine: a survey of how medical students, residents, and faculty use smartphones and other mobile devices to find information. *J Med Libr Assoc JMLA.* 2014;102(1):22-30. doi:10.3163/1536-5050.102.1.006.

⁶ Nabors C, Peterson SJ, Aronow WS, et al. Mobile physician reporting of clinically significant events—a novel way to improve handoff communication and supervision of resident on call activities. *J Patient Saf.* 2014;10(4):211-217. doi:10.1097/PTS.0b013e31829952ff.

⁷ Wu RC, Tzanetos K, Morra D, Quan S, Lo V, Wong BM. Educational impact of using smartphones for clinical communication on general medicine: more global, less local. *J Hosp Med.* 2013;8(7):365-372. doi:10.1002/jhm.2037.

1 Whereas, Studies have indicated that common advantages of mobile device integration are
2 improved access to research and medical journals⁸, increased learning through medical apps
3 and online resources,¹ reduced administrative burden,^{4,9,10} increased efficiency in clinical care,
4 decreased rounding times, and increased face-to-face patient care;¹¹ and
5

6 Whereas, While there are advantages of integrating mobile devices in medical education and
7 clinical training, risks include reducing resident autonomy, creating possible Health Insurance
8 Portability and Accountability Act violations, and increasing nosocomial infections; therefore be it
9

10 RESOLVED, That our American Medical Association encourage further research in integrating
11 mobile devices in clinical care, particularly to address challenges of reducing work burden while
12 maintain clinical autonomy for residents and fellows (New HOD Policy); and be it further
13

14 RESOLVED, That our AMA collaborate with the Accreditation Council for Graduate Medical
15 Education to develop germane policies, especially with consideration of potential financial
16 burden and personal privacy of trainees, to ensure a more uniform regulation of mobile devices
17 in medical education and clinical training (Directive to Take Action); and be it further
18

19 RESOLVED, That our AMA encourage medical schools and residency programs to educate all
20 trainees on proper hygiene and professional guidelines in using personal devices in clinical
21 environment. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/12/16

⁸ Niehaus W, Boimbo S, Akuthota V. Physical Medicine and Rehabilitation Resident Use of iPad Mini Mobile Devices. PM R. 2015;7(5):512-518. doi:10.1016/j.pmrj.2015.01.017.

⁹ Schooley B, Walczak S, Hikmet N, Patel N. Impacts of mobile tablet computing on provider productivity, communications, and the process of care. Int J Med Inf. 2016;88:62-70. doi:10.1016/j.ijmedinf.2016.01.010.

¹⁰ Lobo MJ, Crandley EF, Rumph JS, et al. Pilot Study of iPad Incorporation Into Graduate Medical Education. J Grad Med Educ. 2013;5(1):142-144. doi:10.4300/JGME-D-12-00007.1.

¹¹ Crowson MG, Kahmke R, Ryan M, Scher R. Utility of Daily Mobile Tablet Use for Residents on an Otolaryngology Head & Neck Surgery Inpatient Service. J Med Syst. 2016;40(3):55. doi:10.1007/s10916-015-0419-8.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-16)

Introduced by: International Medical Graduates Section
Subject: Formal Leadership Training During Medical Education
Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

1 Whereas, Current training curriculums for physicians are designed to ensure the development of
2 clinical skills necessary to become competent practitioners, yet there is no clearly defined
3 process to encourage and sustain leadership skills acquisition essential to successful transition
4 to independent practice; and
5
6 Whereas, Effective leadership is vital to creation of an optimal environment for providing high-
7 quality patient care with consistency; and
8
9 Whereas, Physicians who acquire insufficient leadership qualities and skills within the clinical,
10 operational and financial spheres of practice may face greater challenges in navigating the ever-
11 changing United States healthcare environment and in maintaining high standards of care while
12 minimizing healthcare disparities; therefore be it
13
14 RESOLVED, That our American Medical Association advocate for and support the creation of
15 programs and curricula that emphasize experiential and active learning models which are
16 inclusive of leadership knowledge, skills and the qualities utilized in the clinical setting through
17 direct observation and which foster a shared learning environment with the entire
18 interdisciplinary care team (Directive to Take Action); and be it further
19
20 RESOLVED, That our AMA advocate for and support the creation of programs and curricula to
21 develop the leadership competencies and foundational skills for medical practitioners necessary
22 to effectively understand and navigate current and future policy changes from the Center for
23 Medicare and Medicaid Services, while continuing to maintain said practitioners fiduciary
24 responsibility and high-quality patient care (Directive to Take Action); and be it further
25
26 RESOLVED, That our AMA advocate with the Liaison Committee for Medical Education,
27 Association of American Medical Colleges and other governing bodies responsible for the
28 education of future physicians to implement programs early in medical training to promote the
29 development of leadership capabilities, so that all doctors obtain a minimum standard of
30 leadership and management skills. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/20/16

References:

1. Warren OJ, Carnall R. Medical leadership: why it's important, what is required and how we develop it. *Postgrad Med Jour* 2011;87: 27-32.
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3. Wojtczack A. Leadership development: prerequisite for successful public-private partnership. New challenge for medical schools: graduates' outcome competences in health leadership. *World Hospital Health Serv*. 2003; 39(1): 27-29, 31, 33.
4. Vermeulen B, Carron PN. The importance of teamwork in emergency medicine. training. *Revue Medicale Suisse*. 2007; 3(21): 1813-1816.
5. Pullen ML. Developing clinical leadership skills in student nurses. *Nurse Education Today*. 2003; 23(1): 34-39.
6. Martins HM. Why management and leadership education for internists. *European Journal of Internal Medicine*, 2010 Oct; 21(5): 374-6.
7. Schwartz RW, Pogge C. Physician leadership: essential skills in a changing environment. *American Journal of Surgery*, 2000 Sep;180(3):187-92.
8. Gagliano NJ, Ferris T, Colton D, Dubitzky A, Hefferman J, Torchiana D. A physician leadership development program at an academic medical center. *Quality Management Health Care*, 2010 Jul-Sep; 19(3):231-8.
9. Stoller JK, Berkowitz E, Bailin PL. Physician management and leadership education at the Cleveland Clinic Foundation: program impact and experience over 14 years. *Journal of Medical Practice Management*, 2007, Jan-Feb;22(4):237-42.
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11. Leatt P, Porter J. Where are the healthcare leaders? The need for investment in leadership development. *Healthcare papers*. 2003;4:14-31.
12. Schwartz RA, Pogge CR, Gillis SA, Holsinger JW. Programs for the development of physician leaders: a curricular process in its infancy. *Academic Medicine*, 2000;75:133-140.

RELEVANT AMA POLICY

AMA Mission and Vision G-625.010

Mission: To promote the art and science of medicine and the betterment of public health.

Core Values: (1) Leadership; (2) Excellence; and (3) Integrity and Ethical Behavior.

Vision: To be an essential part of the professional life of every physician.

BOT Rep. 1, A-01, Consolidated: CLPRD Rep. 3, I-01, Modified: BOT Rep. 2, A-02, Reaffirmed, BOT Rep. 1, A-03, Modified: BOT Rep. 14, I-03, Modified: BOT Rep. 22, I-06, Reaffirmed: BOT Rep. 5, A-11, Reaffirmation A-11, Reaffirmed: BOT Rep. 4, I-11

AMA Sponsored Leadership Training for Hospital Medical Staff Officers and Committee Chairs H-225.972

It is the policy of the AMA (1) to offer, both regionally and locally, extensive training and skill development for emerging medical staff leaders to assure that they can effectively perform the duties and responsibilities associated with medical staff self-governance; and (2) that training and skill development programs for medical staff leaders be as financially self-supporting as feasible.

Res. 808, I-91, Reaffirmed: Sunset Report, I-01, Reaffirmed: CMS Rep. 7, A-11

Management and Leadership for Physicians D-295.316

1. Our AMA will study advantages and disadvantages of various educational options on management and leadership for physicians with a report back to the House of Delegates; and develop an online report and guide aimed at physicians interested in management and leadership that would include the advantages and disadvantages of various educational options.

2. Our AMA will work with key stakeholders to advocate for collaborative programs between medical schools and related schools of business and management to better prepare physicians for administrative and leadership responsibilities in medical management.

Sub. Res. 918, I-14

Initiative to Transform Medical Education: Strategies for Medical Education Reform H-295.871

Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role.

CME Rep. 13, A-07

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(I-16)

Introduced by: Organized Medical Staff Section
Subject: Inappropriate Uses of Maintenance of Certification
Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

1 Whereas, Many hospitals and health care organizations impose Maintenance of Certification
2 (MOC) as a requirement for medical staff membership, credentialing, and/or hospital privileges,
3 essentially making MOC mandatory for all physician members on the medical staff; and
4
5 Whereas, Most insurance companies not only impose MOC requirements for physicians who
6 wish to participate in and maintain their insurance panel membership, but may also require that
7 physicians be board certified in order to receive any reimbursement for services rendered,
8 regardless of their network status; and
9
10 Whereas, There remain widespread and valid concerns relating to the occurrence of legislative
11 efforts that would require all physicians to participate in "time-limited" board certification and other
12 associated MOC programs in order to maintain their state medical license; and
13
14 Whereas, The MOC process is expensive, time-consuming, disruptive to physicians' lives and
15 practices, and decreases the time available for patient care; and
16
17 Whereas, There is little evidence that the MOC process is effective in accomplishing the goal of
18 improved clinical outcomes based upon improved professional performance; therefore be it
19
20 RESOLVED, That our American Medical Association, through legislative, regulatory, and
21 collaborative efforts, advocate that Maintenance of Certification not be a requirement for: (1)
22 medical staff membership, privileging, or credentialing; (2) insurance panel participation; or (3)
23 state medical licensure. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/30/16

The topic of this resolution is currently under study by the Council on Medical Education.

RELEVANT AMA POLICY

H-230.997 Recertification and Hospital or Health Plan Network Privileges

(1) The fact that a board certified practitioner fails to undergo the recertification examination shall not be adequate reason to modify or withhold hospital privileges or health plan network status from a physician. (2) Modification or withholding of hospital privileges or health plan network status shall be purely on the basis of assessment of performance. (Res. 26, A-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: Res. 727, A-06; Reaffirmed: CMS Rep. 01, A-16)

H-275.924 Maintenance of Certification

AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit?, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
 13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
 14. MOC should be used as a tool for continuous improvement.
 15. The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation or employment.
 16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
 17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
 18. MOC activities and measurement should be relevant to clinical practice.
 19. The MOC process should not be cost prohibitive or present barriers to patient care.
 20. Any assessment should be used to guide physicians' self-directed study.
 21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
 22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
 23. Physicians with lifetime board certification should not be required to seek recertification.
 24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
 25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
- (CME Rep. 16, A-09 Reaffirmed: CME Rep. 11, A-12 Reaffirmed: CME Rep. 10, A-12, Reaffirmed in lieu of Res. 313, A-12, Reaffirmed: CME Rep. 4, A-13, Reaffirmed in lieu of Res. 919, I-13, Appended: Sub. Res. 920, I-14, Reaffirmed: CME Rep. 2, A-15, Appended: Res. 314, A-15, Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(I-16)

Introduced by: Medical Student Section

Subject: Promoting and Reaffirming Domestic Medical School Clerkship Education

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

1 Whereas, Pursuant to existing AMA policy D-295.320, our AMA will advocate for regulations
2 that would ensure clinical clerkship slots be given first to students of US medical schools that
3 are Liaison Committee on Medical Education- or Commission on Osteopathic College
4 Accreditation-approved, or schools currently given preliminary accreditation status, provisional
5 accreditation status, or equivalent, from either of the above bodies; and
6

7 Whereas, Pursuant to existing AMA policy D-295.320, our AMA will advocate for federal and
8 state legislation or regulations to oppose any extraordinary compensation for clinical clerkship
9 sites by medical schools or other clinical programs that would result in displacement or
10 otherwise limit the training opportunities of United States LCME/COCA students in clinical
11 rotations; and
12

13 Whereas, Pursuant to existing AMA policy D-295.931, our AMA opposes any arrangements of
14 US medical schools or their affiliated hospitals that allow the presence of visiting students to
15 disadvantage their own students educationally or financially; and
16

17 Whereas, LCME Standard 5, Element 5.10, Resources Used by Transfer/Visiting Students,
18 states, "The resources used by a medical school to accommodate any visiting and transfer
19 students in its medical education program do not significantly diminish the resources available
20 to already enrolled medical students."¹
21

22 Whereas, Data compiled from the 2012 LCME Annual Medical Questionnaire showed that in the
23 past 2-3 years, 53 percent of medical schools have found it more difficult to find inpatient clinical
24 placements for students in core clinical clerkships, and 18 percent attributed the increased
25 difficulty to "competition for placement sites from offshore international medical schools";²
26

27 Whereas, To gain access, some for-profit offshore medical schools pay hospitals in the United
28 States for their students' clinical training;² and
29

30 Whereas, The educational experience of US medical students could be compromised by their
31 having to compete for faculty attention and access to patients with visiting students;² therefore
32 be it
33

34 RESOLVED, That our American Medical Association pursue legislative and/or regulatory
35 avenues that promote the regulation of the financial compensation which medical schools can
36 provide for clerkship positions in order to facilitate fair competition amongst medical schools and
37 prevent unnecessary increases in domestically-trained medical student debt (Directive to Take
38 Action); and be it further

¹ 2017-2018 Functions and Structure of a Medical School. Available at: <http://lcme.org/publications/>

² CME Report 1, I-13

- 1 RESOLVED, That our AMA support the expansion of partnerships of foreign medical schools
2 with hospitals in regions which lack local medical schools in order to maximize the cumulative
3 clerkship experience for all students (New HOD Policy); and be it further
4
5 RESOLVED, That our AMA reaffirm policies D-295.320, D-295.931, and D-295.937.
6 (Reaffirm HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/30/16

RELEVANT AMA POLICY

Factors Affecting the Availability of Clinical Training Sites for Medical Student Education

D-295.320 - Our AMA will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion. 2. Our AMA will encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students. 3. Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured. 4. Our AMA will advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation- approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies. 5. Our AMA will advocate for federal and state legislation or regulations to oppose any extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities of United States LCME/COCA students in clinical rotations. CME Rep. 4, I-09 Appended: Sub. Res. 302, A-12 Modified: Res. 903, I-12 Modified: CME Rep. 1, I-13

Update on the Availability of Clinical Training Sites for Medical Student Education D-

295.931 - Our AMA will work with appropriate collaborators to study how to build additional institutional and faculty capacity in the US for delivering clinical education. 2. Our AMA, in collaboration with interested stakeholders, will: (a) study options to require that students from international medical schools who desire to take clerkships in US hospitals come from medical schools that are approved by an independent public or private organization, such as the Liaison Committee on Medical Education, using principles consistent with those used to accredit US medical schools; (b) advocate for regulations that will assure that international students taking clinical clerkships in US medical schools come from approved medical schools that assure educational quality that promotes patient safety; and (c) advocate that any institution that accepts students for clinical placements be required to assure that all such students are trained in programs that meet requirements for curriculum, clinical experiences and attending supervision as expected for Liaison Committee on Medical Education and American Osteopathic Association accredited programs. 3. Our AMA will study whether the public service community benefit commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level. 4. Our AMA opposes any arrangements of US medical schools or their affiliated hospitals that allow the presence of

visiting students to disadvantage their own students educationally or financially. CME Rep. 2, I-08 Modified: CME Rep. 4, I-09 Reaffirmed: CME Rep. 1, I-13

Competition for Clinical Training Sites D-295.937 - Our AMA will, through the Council of Medical Education, conduct an analysis of the adequacy of clinical training sites to accommodate the increasing number of medical students in the US accredited medical schools and study the impact of growing pressure, including political and financial, to accommodate clinical training in US hospitals for US citizen international medical students. Res. 324, A-08

AMA Principles on International Medical Graduates H-255.988 - Our AMA supports: 1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada. 2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE. 3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body. 4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada. 5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees. 6. The core clinical curriculum of a foreign medical school should be provided by that school; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school. 7. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools. 8. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care. 9. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs. 10. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure. 11. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower. 12. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor. 13. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. 14. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities. 15. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs. 16. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members. 17. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c)

identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools. 18. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine. 19. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations. 20. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return. 21. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States. 22. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation. 23. Providing U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school. 24. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state. BOT Rep. Z, A-86 Reaffirmed: Res. 312, I-93 Modified: CME Rep. 2, A-03 Reaffirmation I-11 Reaffirmed: CME Rep. 1, I-13 Modified: BOT Rep. 25, A-15 Modified: CME Rep. 01, A-16

Foreign Medical Graduates H-255.987 - 1. Our AMA supports continued efforts to protect the rights and privileges of all physicians duly licensed in the US regardless of ethnic or educational background and opposes any legislative efforts to discriminate against duly licensed physicians on the basis of ethnic or educational background. 2. Our AMA will: (a) continuously study challenges and issues pertinent to IMGs as they affect our country's health care system and our physician workforce; and (b) lobby members of the US Congress to fund studies through appropriate agencies, such as the Department of Health and Human Services, to examine issues and experiences of IMGs and make recommendations for improvements. Res. 56, A-86 Reaffirmed: Sunset Report, I-96 Reaffirmation A-00 Reaffirmed: CME Rep. 2, A-10 Reaffirmed: CME Rep. 11, A-10 Appended: Res. 303, A-10 Reaffirmation A-11 Reaffirmation A-12

Foreign Medical Graduates H-255.998 - Our AMA supports the following principles, based on recommendations of the Ad Hoc Committee on Foreign Medical Graduates (FMGs): Our AMA supports the practice of U.S. teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. CME Rep. F, A-81 Reaffirmed: CLRPD Rep. F, I-91 Modified: Sunset Report, I-01 Reaffirmed: CME Rep. 2, A-11

Graduates of Foreign Health Professional Schools H-255.985 - (1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices. BOT Rep. NN, A-87 Reaffirmed: Sunset Report, I-97 Reaffirmed: Res. 320 and Res. 305, A-03 Reaffirmed: CME Rep. 1, I-03 Reaffirmed: CME Rep. 2, A-13

Preservation of Opportunities for US Graduates and International Medical Graduates Already Legally Present in the US H-255.974 - In the event of reductions in the resident workforce, the AMA will advocate for a mechanism of resident selection which promotes the maintenance of resident physician training opportunities for all qualified graduates of United States Liaison Committee on Medical Education and American Osteopathic Association accredited institutions; and the AMA adopts the position that it will be an advocate for IMGs already legally present in this country. Res. 324, A-97 Reaffirmed: CME Rep. 10, A-99 Reaffirmed: CME Rep. 2, A-09

Demonstration of Clinical Competence H-275.956

It is the policy of the AMA to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools and should not be used for licensure of graduates of Liaison Committee on Medical Education (LCME)- and American Osteopathic Association (AOA)-accredited medical schools or of Educational Commission for Foreign Medical Graduates (ECFMG)-certified physicians. CME Rep. E, A-90 Reaffirmed: CME Rep. 5, A-99 Modified: Sub. Res. 821, I-02 Modified: CME Rep. 1, I-03 Reaffirmed: CME Rep. 16, A-09 Reaffirmed in lieu of Res. 313, A-12

Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968 - Our AMA: 1. Supports the autonomy of medical schools to determine optimal tuition requirements for international students; 2. Encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance; 3. Supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR?); and 4. Encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school. CME Rep. 5, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(I-16)

Introduced by: Michigan

Subject: Development of Alternative Competency Assessment Models

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

1 Whereas, Hospitals, medical offices, skilled nursing facilities, and third party payers have used
2 board certification, board recertification, and maintenance of certification (MOC) as one tool for
3 assessing initial and ongoing clinical competency; and
4

5 Whereas, MOC and board recertification have not been shown to provide proof of a higher level
6 of clinical competency; and
7

8 Whereas, MOC is being challenged because of this lack of evidence; and
9

10 Whereas, Various organizations are looking for other methods to determine ongoing clinical
11 competency; therefore be it
12

13 RESOLVED, That our American Medical Association amend AMA Policy H-275.936,
14 Mechanisms to Measure Physician Competency, by addition and deletion to read as follows:
15

16 Our AMA (1) works with the American College of Graduate Medical Education,
17 American Board of Medical Specialties, and other relevant organizations to develop
18 alternative and more accurate methods to determine ongoing clinical competency; (2)
19 reviews and proposes improvements for assuring continued physician competence,
20 including but not limited to performance indicators, board certification and
21 recertification, professional experience, continuing medical education, and teaching
22 experience; and (2)(3) opposes the development and/or use of "Medical Competency
23 Examination" and establishment of oversight boards for current state medical boards
24 as proposed in the fall 1998 Report on Professional Licensure of the Pew Health
25 Professions Commission, as an additional measure of physician competency. (Modify
26 Current HOD Policy)

Fiscal Note: Minimal - less than \$1,000.

Received: 09/30/16

The topic of this resolution is currently under study by the Council on Medical Education.

RELEVANT AMA POLICY

Mechanisms to Measure Physician Competency H-275.936

Our AMA (1) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board certification and recertification, professional experience, continuing medical education, and teaching experience; and (2) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional Licensure of the Pew Health Professions Commission, as an additional measure of physician competency.

Res. 320, I-98 Amended: Res. 817, A-99 Reaffirmed: CME Rep. 7, A-02 Reaffirmed: CME Rep. 7, A-07 Reaffirmed: CME Rep. 16, A-09 Reaffirmed in lieu of Res. 313, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(I-16)

Introduced by: Michigan

Subject: Maintenance of Certification and Insurance Plan Participation

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

- 1 Whereas, Board certification has been accepted by insurance companies as a measure of
2 expertise; and
3
4 Whereas, Board certification has often been required for insurance program participation; and
5
6 Whereas, Maintenance of certification (MOC) is a new concept; and
7
8 Whereas, MOC has never been proven to demonstrate more expertise or better patient care
9 than board certification; and
10
11 Whereas, Insurance companies may begin to require MOC as a criterion for participation with
12 insurance plan panels; therefore be it
13
14 RESOLVED, That our American Medical Association increase its efforts to work with the
15 insurance industry to ensure that maintenance of certification does not become a requirement
16 for insurance panel participation. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 09/30/16

The topic of this resolution is currently under study by the Council on Medical Education.

RELEVANT AMA POLICY

Maintenance of Certification H-275.924

AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.
11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
14. MOC should be used as a tool for continuous improvement.
15. The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation or employment.
16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
18. MOC activities and measurement should be relevant to clinical practice.
19. The MOC process should not be cost prohibitive or present barriers to patient care.
20. Any assessment should be used to guide physicians' self-directed study.
21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
23. Physicians with lifetime board certification should not be required to seek recertification.
24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

Citation: CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13; Appended: Sub. Res. 920, I-14; Reaffirmed: CME Rep. 2, A-15; Appended: Res. 314, A-15; Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(I-16)

Introduced by: Michigan

Subject: Prevent Maintenance of Certification Licensure and Hospital Privileging Requirements

Referred to: Reference Committee C
(Martin D. Trichtinger, MD, Chair)

1 Whereas, Board certification is a vigorous and arduous process; and
2
3 Whereas, Board certification has been long accepted as a measure of tested expertise; and
4
5 Whereas, Continuing medical education (CME) has been required to insure continuing
6 expertise and as a condition for license renewal; and
7
8 Whereas, Maintenance of certification (MOC) is a fairly new process with unproven benefit
9 that is a separate process from board certification and CME; and
10
11 Whereas, The American Board of Medical Specialties has been trying to link MOC with state
12 licensure requirements; and
13
14 Whereas, Some hospitals are now requiring MOC for privileging; and
15
16 Whereas, There are no evidence-based studies that the newly required MOC enhances
17 physician performance or patient care; and
18
19 Whereas, The MOC process is expensive and disruptive in physicians' lives and practices;
20 and
21
22 Whereas, The MOC process decreases a physician's time available for patient care; and
23
24 Whereas, There have been numerous resolutions attempting to point out the problems of
25 MOC; and
26
27 Whereas, Despite these resolutions, MOC abuses persist; therefore be it
28
29 RESOLVED, That our American Medical Association, consistent with Policy H-275.924,
30 vigorously advocate by legislation, regulation, or other appropriate activity to prevent the use
31 of maintenance of certification as a licensing requirement in any state; (Directive to Take
32 Action) and be it further

1 RESOLVED, That our AMA amend Policy H-275.924, "Maintenance of Certification," Bullet
2 No. 15, by addition to read as follows:

3

4 15. The MOC program should not be a mandated requirement for licensure,
5 credentialing, hospital privileging, reimbursement, network participation or employment.
6 (Modify Current HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 09/30/16

The topic of this resolution is currently under study by the Council on Medical Education.

RELEVANT AMA POLICY

Maintenance of Certification H-275.924

AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.
 12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
 13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.
 14. MOC should be used as a tool for continuous improvement.
 15. The MOC program should not be a mandated requirement for licensure, credentialing, reimbursement, network participation or employment.
 16. Actively practicing physicians should be well-represented on specialty boards developing MOC.
 17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.
 18. MOC activities and measurement should be relevant to clinical practice.
 19. The MOC process should not be cost prohibitive or present barriers to patient care.
 20. Any assessment should be used to guide physicians' self-directed study.
 21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
 22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.
 23. Physicians with lifetime board certification should not be required to seek recertification.
 24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.
 25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.
- Citation: CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13; Appended: Sub. Res. 920, I-14; Reaffirmed: CME Rep. 2, A-15; Appended: Res. 314, A-15; Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16

An Update on Maintenance of Licensure D-275.957

- Our American Medical Association will:
1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.
 2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.
 3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.
 4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.
 5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.
 6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.
 7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.
 8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.
- Citation: (CME Rep. 3, A-15; Modified: CME Rep. 2, I-15)

MOC Provisions of Interstate Medical Licensure Compact D-275.955

Our American Medical Association will, in collaboration with the Federation of State Medical Boards and interested state medical boards, request a clarifying statement from the Interstate Medical Licensure Compact Commission that the intent of the language in the model legislation requiring that a physician "holds" specialty certification refers only to initial specialty certification recognized by the American Board of Medical Specialties or the American Osteopathic Association's (AOA's) Bureau of Osteopathic Specialists and that there is no requirement for participation in ABMS's Maintenance of Certification or AOA's Osteopathic Continuous Certification (OCC) program in order to receive initial or continued licensure under the Interstate Medical Licensure Compact.

Citation: (Res. 235, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(I-16)

Introduced by: Maryland

Subject: Eliminating the Tax Liability for Payment of Student Loans

Referred to: Reference Committee C
(Martin J. Trichtinger, MD, Chair)

-
- 1 Whereas, It may be difficult to recruit physicians to underserved areas where there are
2 physician shortages; and
3
4 Whereas, Private employers offering student loan repayment to physicians that agree to work in
5 underserved areas could help to alleviate physician shortages in these areas; and
6
7 Whereas, The current tax code requires funds given by the private employers to physicians to
8 repay student loans to be considered ordinary income and a tax liability; and
9
10 Whereas, The private employers would need to provide additional funds to the physicians to
11 cover the tax liability which significantly increases the cost of repayment of student loans;
12 therefore be it
13
14 RESOLVED, That our American Medical Association work with the Internal Revenue Service to
15 eliminate the tax liability when private employers provide the funds to repay student loans for
16 physicians who agree to work in an underserved area. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000.

Received: 10/11/16

RELEVANT AMA POLICY

Effectiveness of Strategies to Promote Physician Practice in Underserved Areas D-200.980

1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations. (b) Permanent reauthorization and expansion of the Conrad State 30 J-1 visa waiver program. (c) Adequate funding (up to at least FY 2005 levels) for programs under Title VII of the Health Professions Education Assistance Act that support educational experiences for medical students and resident physicians in underserved areas.
 2. Our AMA encourages medical schools and their associated teaching hospitals, as well as state medical societies and other private sector groups, to develop or enhance loan repayment or scholarship programs for medical students or physicians who agree to practice in underserved areas or with underserved populations.
 3. Our AMA will advocate to states in support of the introduction or expansion of tax credits and other practice-related financial incentive programs aimed at encouraging physician practice in underserved areas.
 4. Our AMA will advocate for the creation of a national repository of innovations and experiments, both successful and unsuccessful, in improving access to and distribution of physician services to government-insured patients (National Access Toolbox).
- CME Rep. 1, I-08 Modified: CME Rep. 4, A-10 Reaffirmation I-11 Appended: Res. 110, A-12 Reaffirmation A-13 Reaffirmation A-14