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The following is a preliminary report of actions taken by the House of Delegates at its 2024 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-24)

Final Report of Reference Committee C

Cheryl Gibson Fountain, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 1 - Medication Reconciliation Education

2. Council on Medical Education Report 2 - Updates to Recommendations for Future Directions for Medical Education

3. Resolution 302 - Strengthening Parental Leave Policies for Medical Trainees and Recent Graduates

RECOMMENDED FOR ADOPTION AS AMENDED

4. Resolution 304 - Payment and Benefit Parity for Fellows

5. Resolution 306 - Streamlining Continuing Medical Education Across States and Medical Specialties

RECOMMENDED FOR REFERRAL

6. Resolution 305 - Removing Board Certification as a Requirement for Billing for Home Sleep Studies

Amendments:
If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL EDUCATION REPORT 1 - MEDICATION RECONCILIATION EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 1 be adopted and the remainder of the report be filed.

1. Amend AMA Policy D-120.965 "Pharmacy Review of First Dose Medication" by addition of a new third clause to read as follows:

   3. Our AMA a) recognizes that medication reconciliation is a multidisciplinary process and b) supports education of physicians-in-training about the physician's role and responsibilities in medication reconciliation and management within a physician-led team in relevant clinical settings, to minimize medical errors and promote patient safety and quality of care.

2. Amend AMA Policy D-120.965 with a change in title to read as follows:

   MEDICATION RECONCILIATION TO IMPROVE PATIENT SAFETY

3. Reaffirm AMA Policy H-160.902 "Hospital Discharge Communications"

The recommendations in Council on Medical Education Report 1 received supportive online testimony from the author as well as the Council on Medical Education and others. The only live testimony was from the Council in support of their report. Continuing education on medication reconciliation was also addressed in the remainder of Resolution 805-I-23, which is now AMA Policy D-300.973 "Medication Reconciliation Education". There was no opposing testimony. Your Reference Committee appreciates the Council's work and recommends that CME 1-I-24 be adopted.

(2) COUNCIL ON MEDICAL EDUCATION REPORT 2 - RECOMMENDATIONS FOR FUTURE DIRECTIONS FOR MEDICAL EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Council on Medical Education Report 2 be adopted and the remainder of the report be filed.

HOD ACTION: Recommendations in Council on Medical Education Report 2 be adopted and the remainder of the report be filed.

1. Study the restructuring of AMA Policy H-295.995, "Recommendations for Future Directions for Medical Education" in a series of seven future reports based on the topics of 1) mission of medical education, 2) professional regulation, 3) entry into and transition through the medical education continuum, 4) medical education curricula, 5) physician as medical professional, 6) medical education systems, and 7) obligations to students and trainees, to consolidate existing AMA policies in these areas where appropriate and to recommend new language for the future of medical education. (Directive to Take Action)

2. Policy H-295.995, "Recommendations for Future Directions for Medical Education," be amended by deletion of items 19, 20, 31 and 33 and appropriately renumbered to read as follows (Modify Current HOD Policy):

(19) ~~The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.~~

(20) ~~The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.~~

(31) ~~The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.~~

(33) ~~The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.~~

The recommendations in Council on Medical Education Report 2 received supportive online and live testimony, including from the Council on Medical Education as the author, and others. There was no opposing testimony. An amendment was offered requesting an additional recommendation in support of increasing and retaining Black and African American learners in medical school, as well as other marginalized groups. Your Reference Committee acknowledges the deep importance of this work and existing AMA policy Minorities in the Health Professions H-350.978, which states: "(7) The AMA reaffirms its support of: (a) efforts to increase the number of black Americans and other minority Americans entering and graduating from U.S. medical schools; and (b) increased financial aid from public and private sources for students from low income, minority and socioeconomically disadvantaged backgrounds." Additional relevant AMA policies include Underrepresented Student Access to US Medical Schools H-350.960 and Racial and Ethnic Disparities in Health Care H-350.974. The Council on Medical Education noted that CME 2-I-24 proposes a framework to consolidate and modernize AMA medical education policy via future reports, and seeks approval to utilize staff time and resources to do so. The body of CME 2-I-24 described a future report category of "mission of medical education" that explicitly includes consideration of the history of harms against Black physicians and patients, and work towards a diverse workforce. Your Reference Committee urges the Council to address this issue as intended in that future report to the HOD.

Your Reference Committee is grateful to the Council for this self-led report and its initiative to further address these important issues in future reports, and recommends that CME 2-I-24 be adopted.

(3) RESOLUTION 302 - STRENGTHENING PARENTAL LEAVE POLICIES FOR MEDICAL TRAINEES AND RECENT GRADUATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 302 be adopted.

HOD ACTION: Resolution 302 adopted.

RESOLVED, that our American Medical Association (AMA) amend "Increasing Practice Viability For Physicians Through Increased Employer And Employee Awareness Of Protected Leave Policies" H-405.960 by addition and deletion to read as follows:

4. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave~~.~~, and with eligibility beginning at the start of employment without a waiting period.

Your Reference Committee received supportive online and live testimony, including from the co-authors, Resident and Fellow Section (RFS) and Lesbian, Gay, Bisexual, Transgender, Queer+ (LGBTQ+) Section, as well as the Council on Medical Education, and others. There was individual testimony raising concern that many physicians do not get 12 weeks of leave, but there was no testimony opposing the resolution.

Your Reference Committee acknowledged possible challenges and practical considerations associated with any leave, regardless of immediacy of timing, and concurred with the online testimony that the elimination of the waiting period better aligns with the health of trainee physicians and their families. Your Reference Committee also noted that this change better aligns with current ACGME leave policies, which do not include a waiting period. Thus, your Reference Committee recommends that Resolution 302 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(4) RESOLUTION 304 - PAYMENT AND BENEFIT PARITY FOR FELLOWS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 304 be amended by addition and deletion to read as follows:

RESOLVED, that our American Medical Association (AMA) amend Residents and Fellows' Bill of Rights H-310.912 by addition to read as follows:

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services~~, and will encourage institutions to provide parity in salary and benefits between residents and follows at a level that is at minimum commensurate with their postgraduate year~~.

8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all residents and fellow physicians in ACGME-accredited training programs:

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

2. With regard to compensation, residents and fellows should receive:

a. Compensation for time at orientation.

b. ~~Salaries~~ Compensation, including salary and benefits, commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 304 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 304 be changed to read as follows:

COMPENSATION PARITY FOR RESIDENTS AND FELLOWS

HOD ACTION: Resolution 304 adopted as amended.

RESOLVED, that our American Medical Association (AMA) amend Residents and Fellows' Bill of Rights H-310.912 by addition to read as follows:

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services, and will encourage institutions to provide parity in salary and benefits between residents and fellows at a level that is at minimum commensurate with their postgraduate year.

Your Reference Committee received mixed testimony in the online reference committee. Online testimony also noted that financial funding structures differ between resident and fellowship training, and that GME programs face funding challenges. Your Reference Committee is sensitive to this issue, particularly as it relates to government funding and accreditation. The Council on Medical Education recommended that Policies H-310.929, H-310.912, and H-225.950 be reaffirmed in lieu of this resolution. Your Reference Committee also discussed concern about the use of the term “postgraduate”, given residents may have different numbers of postgraduate years prior to starting a fellowship. Your Reference Committee proposed an amendment by addition and deletion to Policy H-310.912 clause 8.E.2.b. to include “compensation” and “benefits” in the Preliminary Report recommendation. Your Reference Committee also recommended a change in title to more accurately reflect the intent of the resolution and amendments.

Live testimony was broadly supportive of the Preliminary Report recommendation including from the authors. Thus, your Reference Committee recommends that Resolution 304 be adopted as amended.

(5) RESOLUTION 306 - STREAMLINING CONTINUING MEDICAL EDUCATION ACROSS STATES AND MEDICAL SPECIALTIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the third resolve of Resolution 306 be deleted:

~~**RESOLVED, our AMA work with relevant stakeholders to examine the feasibility of a single common continuing medical education requirement for maintaining state licensure; and be it further**~~

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the fourth resolve of Resolution 306 be deleted:

~~**RESOLVED, our AMA advocate any continuing medical education that requires answering questions to be categorized as "Self-Assessment continuing medical education."**~~

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 306 be amended by addition of a new resolve clause to read as follows:

RESOLVED, our AMA advocate that all entities, including licensing and specialty boards, should recognize all AMA PRA credit equally.

RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that Resolution 306 be adopted as amended.

HOD ACTION: Resolution 306 adopted as amended.

RESOLVED, our AMA work with relevant stakeholders to minimize the financial and time burden of reporting continuing medical education, including but not limited to participation in a common reporting standard; and be it further

RESOLVED, our AMA advocate for medical specialty and state medical boards to continue to allow manual entry of continuing medical education until all boards and

continuing medical education providers participate in a common reporting standard; and be it further

RESOLVED, our AMA work with relevant stakeholders to examine the feasibility of a single common continuing medical education requirement for maintaining state licensure; and be it further

RESOLVED, our AMA advocate any continuing medical education that requires answering questions to be categorized as “Self-Assessment continuing medical education.”

Your Reference Committee received mixed online testimony on this item in the online reference committee. While most testimony supported the first and second resolves, there was a variance in testimony on the latter. The Council on Medical Education recommended that the first and second resolves be adopted, the third resolve not be adopted, and they offered alternate language in lieu of the fourth resolve, which was supported by additional testimony. Testimony about the third resolve noted that it conflicts with Policy H-275.917(2B) “An Update on Maintenance of Licensure” (MOL), which states that MOL requirements are under the purview of state medical boards. Also, online and live testimony pointed out that many states have laws which mandate state-specific educational requirements. Regarding the fourth resolve, testimony from the Council noted that the AMA is the owner of the AMA PRA Credit System and defines AMA PRA credit; thus, concern was raised about other bodies self-designating subcategories of AMA PRA credit for recognition (e.g., “self-assessment”) while not accepting other AMA PRA credit. Further online testimony suggested the fourth resolve over-generalizes CME questions. Your Reference Committee was informed that the AMA initiated the “Reimagining PRA” project, which will address some of these points including data reporting and the role of the AMA, as owner of the AMA PRA credit system, and AOA and AAFP credit systems in defining what is recognized as continuing medical education by other entities.

Live testimony was broadly supportive of the Preliminary Report recommendations. Testimony also emphasized that staff from continuing medical education offices should be considered when collaborating with interested parties.

Your Reference Committee believes the testimony offered by the Council provides a sound compromise to the testimony offered and addresses the concerns about the fourth resolve, for which there was broad support in live testimony. Therefore, your Reference Committee recommends that Resolution 306 be adopted as amended.

RECOMMENDED FOR REFERRAL

(6) RESOLUTION 305 - REMOVING BOARD CERTIFICATION AS A REQUIREMENT FOR BILLING FOR HOME SLEEP STUDIES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 305 be referred.

HOD ACTION: Resolution 305 referred for decision.

RESOLVED, that our American Medical Association advocate that the appropriate bodies in United States government to remove Sleep Board Certification and facility accreditation as a requirement for the approval of and payment for home sleep studies.

Your Reference Committee received mixed online and live testimony on this item. Testimony from the author supported the resolution, centered on lack of patient access to home sleep studies. The primary concern expressed by several delegations in support of referral focused on insufficient access to sleep studies. Testimony from one individual also supported the resolution, citing the growth in home sleep devices (e.g., Watchpat, Apple watch), and advocated that licensed physicians be able to offer home sleep testing and receive payment for it. Members testified to their frustration related to not being able to order sleep studies for their patients, be reimbursed for these sleep studies and expressed comfort in being able to refer patients to sleep medicine specialists. The Council on Medical Education, American Board of Medical Specialties, and a delegation also recommended referral of this item in the online reference committee, raising concerns about possible consequences from removing board certification and facility accreditation requirements and favoring study of the latest evidence on access to polysomnography services and patient outcomes.

The American Academy of Sleep Medicine, Chest Caucus and Thoracic Society all testified in opposition to referral citing concerns that this would lower quality of care, while increasing the cost of care in populations with sleep disorders. The linkage between diagnosis of sleep apnea and treatment of sleep apnea was highlighted as potential area where costs would increase. A specialty delegation testified that the issue of access is more about obtaining insurance approval rather than board certification. Testimony also expressed concern regarding ensuring that individuals ordering sleep tests and interpreting the results have been effectively trained. One delegation and one individual recommended to not adopt, noting concerns about the accuracy of the information provided in Resolution 305 as well as the importance of sleep center accreditation to ensure quality sleep services. Testimony also cited AMA policy “Medical Specialty Board Certification Standards” H-275.926 that “opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes."

Your Reference Committee recognizes this is a complex issue involving quality and access to care and is sensitive to how this issue may intersect with the AMA's current efforts to prevent scope creep. Given the many concerns about access to care, reimbursement for home sleep studies and removal of both facility accreditation and board certification requirements brought forward in testimony, your Reference Committee recommends that Resolution 305 be referred for study.

Madam Speaker, this concludes the report of Reference Committee C. I would like to thank Brandon Francis, MD; Rebecca Hayes, MD, MBA, FAAFP; Jayme Looper, MD, MSE; Bhushan H. Pandya, MD, FACP; Scott H. Pasichow, MD, MPH, FACEP; and Charles W. Van Way III, MD. I'd also like to thank staff persons Tanya Lopez, MS; Lena Drake; Richard Pan, MD, MPH; and Amber Ryan, MEd; as well as all those who testified before the Committee.

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