

**American Medical Association – Resident and Fellow Section
2012 Annual Meeting**

ORDER OF BUSINESS

1. Resolution 1 - Skin cancer surveillance through hairdresser and barber education
2. Resolution 2 - The Health Costs of Hydraulic Fracturing
3. Resolution 3 - Opposition to “Personhood” Bills and Constitutional Amendments
4. Resolution 4 - Nasal Naloxone for the Reversal of Opioid Overdose
5. Resolution 5 - Reducing Barriers that Limit Specialty and Subspecialty Choice for Osteopathic Graduates
6. Resolution 6 - Oncofertility and Fertility Preservation Treatment
7. Resolution 7 - Physician Stewardship of Health System Resources
8. Resolution 8 - Health Policy Elective Rotation
9. Resolution 9 - AMA Interim Meeting: Shorten by One Day
10. Resolution 10 - Evaluating the effect of ACGME resident-work hours reforms
11. Report E - Green Initiative
12. Report F - GME Delegates

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 1
(A-12)

Introduced by: Steve Lee, MD and Elizabeth Bailey, MD

Subject: Skin cancer surveillance through hairdresser and barber education

Referred to: RFS Reference Committee

1 WHEREAS, melanoma of the scalp and neck has a poorer prognosis than melanoma of any other
2 anatomic site with a 5-year survival probability of 83.1% for stage I melanoma of the scalp and neck
3 compared to 92.1% for stage I melanoma of other sites ¹; and
4

5 WHEREAS, the relatively high fatality rate of melanoma of the scalp and neck is likely related to the
6 difficulty of finding them during patient self-examinations and physician routine examinations²; and
7

8 WHEREAS, hairdressers and barbers can reach demographic groups that have poorer skin cancer
9 outcomes and are less likely to see a physician for regular screening, and
10

11 WHEREAS, observational training for barbers and hairdressers does not represent a scope of practice
12 threat to physicians, and
13

14 WHEREAS, 90% of 204 hairdressers in a 2011 study demonstrated a basic understanding of skin cancer
15 knowledge ²; and
16

17 WHEREAS, 49% of those hairdressers “very” or “extremely” interested in participating in a skin cancer
18 education program ²; and
19

20 WHEREAS, such skin cancer educational programs exist in preliminary forms ²; therefore be it
21

22 RESOLVED, That our AMA assist the American Academy of Dermatology identify and develop one or
23 more skin cancer education programs for barbers and hairdressers; and be it further
24

25 RESOLVED, That our AMA assist the American Academy of Dermatology investigate mechanisms for
26 referral of identified individuals to qualified health care providers; and be it further
27

28 RESOLVED, That our AMA help the American Academy of Dermatology advocate for skin cancer
29 education for barbers and hairdressers by states’ Departments of Health.

Fiscal note: Less than \$500

1. Lachiewicz AM, Berwick M, Wiggins CL, Thomas NE. Survival differences between patients with scalp or neck melanoma and those with melanoma of other sites in the Surveillance, Epidemiology, and End Results (SEER) program. *Arch Dermatol.* Apr 2008;144(4):515-521.

2. Bailey EE, Marghoob AA, Orengo IF, Testa MA, White VR, Geller AC. Skin cancer knowledge, attitudes, and behaviors in the salon: a survey of working hair professionals in Houston, Texas. *Arch Dermatol.* Oct 2011;147(10):1159-65

Relevant AMA and RFS Policy:

35.999R Role of Medical Paraprofessionals

Recommended that the: (5) AMA-RFS adopt the position that where overlap exists in professional activities, there should be dialogue and mutual cooperation among all professions, but the physician should assume the leadership role and maintain ultimate responsibility for health care delivery. (RFS

Report D, I-84; Reaffirmed: RFS Report C, I-94) (Reaffirmed Report F, A-05)

165.996R The Fundamental Importance of Universal Access

Asked (1) that the AMA-RFS strongly assert that the fundamental goal of any change in the American health care system should be to move toward increased access to quality health care for every American citizen; and (2) that the AMA-RFS accept access to high quality health care for all Americans as a clear guiding principle in evaluating and responding to proposals to change the American health care system. (RFS Substitute Resolution 33, I-95) [See also:

AMA Policy H-165.918, H-165.969] (Reaffirmed, Report C, I-05)

170.998R Promoting Prevention Strategies in Waiting Rooms

Asked that our AMA encourage healthcare settings to place in their waiting rooms interactive media promoting preventive health measures, empowering patients to become more proactive about their health. (RFS Resolution 8, I-06)

H-55.976 Skin Cancer Prevention Education in Communities of Color

Our AMA: (1) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color; and (2) will work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color. (Res. 510, A-10)

H-55.980 Skin Cancer Self-Examination

The AMA (2) encourages physicians to examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (3) urges physicians to encourage their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (4) encourages physicians to educate their patients concerning the correct way to perform skin self-examination. (Sub. Res. 505, A-96; Reaffirmation I-98; Reaffirmed: CSAPH Rep. 2, A-08)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 2
(A-12)

Introduced by: Massachusetts Medical Society – Resident and Fellow Section

Subject: The Health Costs of Hydraulic Fracturing

Referred to: Reference Committee

- 1 WHEREAS, High-volume hydraulic fracturing, or fracking, as a means of natural gas extraction
2 employed in deep natural gas well drilling enables natural gas to flow more freely out of the well
3 (1); and
4
- 5 WHEREAS, Fracking additionally involves drilling thousands of feet below the earth's surface
6 and pumping millions of gallons of water and chemical additives at high pressure into the well
7 (1); and
8
- 9 WHEREAS, Fracking is exempt from the Safe Drinking Water Act of 2005, thus allowing
10 companies to conceal the chemicals used in the process; and
11
- 12 WHEREAS, In aquifers overlying the Marcellus and Utica shale formations of northeastern
13 Pennsylvania and upstate New York, systematic evidence for methane contamination of
14 drinking water associated with fracking has been documented (2); and
15
- 16 WHEREAS, Wastewater from fracking operations containing high levels of radioactive
17 contaminants is being released into waterways supplying drinking water (3, 4); and
18
- 19 WHEREAS, Fracking has the potential to impose short-term and long-term impacts on
20 underground and surface drinking water resources and local air quality (3); and
21
- 22 WHEREAS, Early studies of the health effects of fracking demonstrate that more than 75% of
23 the toxic chemicals used during both the fracturing and drilling phases of gas operations can
24 affect the skin, eyes, and other sensory organs, the respiratory system, the gastrointestinal
25 system and the liver. Over half the chemicals show effects in the brain and nervous system.
26 More than 25% of the chemicals can cause cancer and mutations. Notably, 37% of the
27 chemicals can affect the endocrine system that encompasses multiple organ systems including
28 those critical for normal reproduction and development (5); and
29
- 30 WHEREAS, The health effects of fracking may be overlooked in the energy industry's haste to
31 leverage the potential of fracking for natural gas extraction; and
32
- 33 WHEREAS, The mission of the AMA is to "promote the betterment of public health" (6);
34 therefore be it
35
- 36 RESOLVED, That our AMA support a moratorium on new expansion of natural gas extraction in
37 populated areas until further scientific information on health impacts is available; and
38
- 39 RESOLVED, That our AMA advocate for statewide disease registries related to potential natural
40 gas drilling effects; and

- 1 RESOLVED, That our AMA support the development of physician and public education on the
2 hydraulic fracturing process, the potential health risks and impact, the estimated health costs of
3 any health impacts to states, insurers, employers and the health care system; and
4
5 RESOLVED, That our AMA advocate for a long-term plan for monitoring and mitigating the
6 health impacts of hydraulic fracturing; and
7
8 RESOLVED, That this resolution be immediately forwarded to the AMA-HOD.

Fiscal Note: \$75,000

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1. Charlez, Philippe A. (1997). Rock Mechanics: Petroleum Applications. Paris: Editions Technip. p.239.
 2. Osborne SG, Vengosh A, Warner NR and Jackson RB. Methane contamination of drinking water accompanying gas-well drilling and hydraulic fracturing. Proceedings of the National Academy of Sciences of the United States of America, 2011. 108: 8172-8176.
 3. Hydraulic Fracturing : Applicability of the Safe Drinking Water Act and Clean Water Act. Science Advisory Board Discussion, 2010. United States Environment Protection Agency. Retrieved 13 March 2012 from <http://yosemite.epa.gov/sab/sabproduct.nsf/>
 4. Urbina, Ian. Regulation Lax as Gas Wells' Tainted Water Hits Rivers. New York Times, 2011. Retrieved 12 March 2012 from http://www.nytimes.com/2011/02/27/us/27gas.html?_r=1
 5. Colborn T, Kwiatkowski C, Schultz K, and Bachran, M. Natural Gas Operations from a Public Health Perspective. International Journal of Human and Ecological Risk Assessment, 2011. 17: 1039-1056.
 6. About AMA: Our Mission. Retrieved 13 March 2012 from <http://www.ama-assn.org/ama/pub/about-ama/our-mission.page>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 3
(A-12)

Introduced by: Albert L. Hsu, MD

Subject: Opposition to "Personhood" Bills and Constitutional Amendments

Referred to: Reference Committee

1 WHEREAS, Colorado voters rejected ballot measures to give constitutional rights to individuals
2 "at the beginning of biological development" in 2008 and 2010;¹ and
3
4 WHEREAS, Mississippi voters defeated Proposition 26: "Should the term "person" be defined
5 to include every human being from the moment of fertilization, cloning, or the equivalent
6 thereof?" in 2011;² and
7
8 WHEREAS, House Bill 1 (2012) was introduced in the Virginia House of Delegates to "construe
9 the word 'person' under Virginia Law ... to include unborn children" and enact that "the life of
10 each human being begins at conception;"³ and
11
12 WHEREAS, House Bill 1 was passed by the Virginia House of Delegates by a vote of 64-34;"⁴
13 and
14
15 WHEREAS, after endorsement by the Senate Education and Health Committee, House Bill 1
16 was tabled to 2013 by the Virginia Senate by a vote of 24-14;^{4,5,6,7,8} and
17
18 WHEREAS, similar "Personhood" bills have also been passed by a single legislative chamber in
19 North Dakota and Alabama;⁷ and
20
21 WHEREAS, In February 2012, the Oklahoma state Senate also voted to pass a "Personhood
22 Act," which would define unborn children at conception to be "persons" under state law;⁹ and
23
24 WHEREAS, Virginia Delegate Bob Marshall, the patron of House Bill 1, stated that his bill would
25 not affect birth control, IVF or abortions but would allow parents to receive damages for the
26 death of a fetus in a wrongful death lawsuit;⁸ and
27
28 WHEREAS, The Medical Society of Virginia testified in opposition to this bill, "on the grounds
29 that if it were enacted, it would create a new cause of action by a fetus against a physician;"¹⁰
30 and
31
32 WHEREAS, these "Personhood" bills and ballot measures would define a person as being a
33 legal entity from the moment of conception; and
34
35 WHEREAS, these "Personhood" bills and ballot measures would define fertilized eggs,
36 embryos, fetuses as persons with constitutional rights separate from those of the pregnant
37 women who carry, nurture, and sustain them; and
38

1 WHEREAS, passage of these “Personhood” bills or ballot measures to give constitutional rights
2 to a fertilized oocyte or early embryo may interfere with the physician-patient relationship in the
3 provision of contraception and in vitro fertilization, as well as potentially criminalize the routine
4 medical and surgical management of life-threatening ectopic pregnancies;¹¹ and
5

6 WHEREAS, passage of these “Personhood” bills or ballot measures to give constitutional rights
7 to a fertilized oocyte or early embryo could complicate the provision of IVF by (1) leaving the
8 status of surplus and cryopreserved embryos undefined, (2) inappropriately pressuring
9 physicians to transfer abnormally-growing and arrested embryos, (3) potentially increasing the
10 rate of dangerous higher-order multiple gestation pregnancies, and (4) confuse the parental
11 status of gamete and embryo donors; and
12

13 WHEREAS, passage of these “Personhood” bills or ballot measures to establish that
14 Personhood begins at conception would potentially give legal protections to ectopic
15 pregnancies, gestational molar pregnancies, and even choriocarcinoma while simultaneously
16 considering monochorionic twins to be two half-persons; and
17

18 WHEREAS, passage of these “Personhood” bills or ballot measures to establish that
19 Personhood begins at conception could empower the government to interfere in the physician-
20 patient relationship during management of pregnancy complications, and potentially give an
21 “estranged husband even more of a legal argument to halt any treatment aimed at saving [the]
22 life of the mom at the expense of [the] unborn,”¹¹ and in certain situations potentially elevate the
23 rights of an embryo above that of the mother; and
24

25 WHEREAS, according to the PersonhoodUSA.com websites, activists seek “Personhood”
26 measures on the ballot this year in at least 12 states, and “authorities have given the green light
27 to gather signatures for proposed ballot measures in Colorado, Ohio, Montana and California,
28 while legislators in Kansas, Virginia, Oklahoma, Wisconsin, Alabama and Georgia have been
29 working on bills that could lead to Personhood referendums;¹² and
30

31 WHEREAS, AMA policy H-160.954 “Criminalization of Medical Judgment” states that our AMA
32 will “take all reasonable and necessary steps to insure that medical decision-making ... does not
33 become a violation of criminal law,” and that “our AMA oppose any future legislation which gives
34 the federal government the responsibility to define appropriate medical practice and regulate
35 such practice through the use of criminal penalties;” and
36

37 WHEREAS, AMA policy H-160.946 “Criminalization of Health Care Decisionmaking” states that
38 our “AMA opposes the attempted criminalization of health care decision-making...;” and
39

40 WHEREAS, AMA policy D-160.999 “Opposition to Criminalizing Health Care Decisions” states
41 that “our AMA will educate physicians regarding the continuing threat posed by the
42 criminalization of healthcare decision-making;” therefore, be it
43

44 RESOLVED, That our AMA oppose any legislation or ballot measures that could criminalize in-
45 vitro fertilization, contraception, or the management of ectopic pregnancies (Establish New
46 Policy); and be it further
47

48 RESOLVED, That our AMA report back on this issue at I-13.

Fiscal Note: Less than \$500

1. "Personhood" amendment fails by 3-1 margin. Denver Post 11/3/10 at <http://www.denverpost.com/headlines/ci_16506253>
2. Mississippi's "Personhood Amendment" fails at the polls. CBS News 11/8/11 at <http://www.cbsnews.com/8301-250_162-57321126/mississippi-personhood-amendment-fails-at-polls/>
3. Virginia House of Delegates, House Bill No 1 at <http://lis.virginia.gov/cgi-bin/legp604.exe?121+ful+HB1+pdf>
4. HB1 Legislative information at <http://lis.virginia.gov/cgi-bin/legp604.exe?121+sum+HB1>
5. Virginia Senate kills 'personhood' anti-abortion bill. USA Today 2/23/12 at <http://www.usatoday.com/news/nation/story/2012-02-23/virginia-personhood-bill-abortion/53228260/1>
6. Virginia Personhood Bill: State Senate Defeats Bill. Huffington Post 2/23/12 at http://www.huffingtonpost.com/2012/02/23/virginia-personhood-bill-defeated-senate_n_1297463.html
7. Virginia "personhood" bill stalls in Senate. Reuters 2/23/12 at <http://www.reuters.com/article/2012/02/24/us-virginia-personhood-idUSTRE81N02720120224>
8. 'Personhood' bill killed for this year by Virginia Senate. Washington Post 2/23/12 at http://www.washingtonpost.com/blogs/virginia-politics/post/personhood-bill-killed-for-this-year-by-virginia-senate/2012/02/23/gIQAyXvBWR_blog.html
9. Anti-abortion "personhood" bill clears Oklahoma senate. Reuters 12/1/12 at <<http://www.reuters.com/article/2012/02/16/us-oklahoma-personhood-idUSTRE81F0ES20120216>>
10. MSV Web Alert – Information on personhood, ultrasound, and abortion bills at http://www.votervoice.net/Core/core.aspx?Screen=Alert&APP=GAC&AID=941&IssueID=27633&SiteID=-1&VV_CULTURE=en-us
11. "Mississippi 'Personhood' law could cause legal mayhem, experts warn. Huffington post 11/7/11 at <http://www.huffingtonpost.com/2011/11/07/mississippi-personhood-la_n_1079710.html>
12. "Multistate personhood push kindles debate" AP report on the Personhood USA website at <http://www.personhoodusa.com/news/multistate-personhood-push-kindles-abortion-debate-ap>

RELEVANT AMA POLICY

H-160.954 Criminalization of Medical Judgment

(1) Our AMA continues to take all reasonable and necessary steps to insure that medical decision-making, exercised in good faith, does not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties. (Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09)

H-160.946 The Criminalization of Health Care Decision-making

The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making. (Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09)

D-160.999 Opposition to Criminalizing Health Care Decisions

Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making." (Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08)

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 4
(A-12)

Introduced by: Massachusetts Medical Society – Resident and Fellow Section and
David Stahl, MD

Subject: Nasal Naloxone for the Reversal of Opioid Overdose

Referred to: Reference Committee

- 1 Whereas, The overall rate of drug overdose and the rate of death from drug overdose is
2 increasing nationwide^{1,2}; and
3
- 4 Whereas, The number of deaths from drug overdose involving opioid analgesics has increased
5 more rapidly than deaths involving any other type of drug³; and
6
- 7 Whereas, Opioid analgesics now account for more overdose deaths than heroin and cocaine
8 combined²; and
9
- 10 Whereas, In August of 2006, the Boston Public Health Commission passed a public health
11 regulation authorizing the distribution of intranasal naloxone to potential bystanders⁴, which
12 resulted in 74 successful overdose reversals after training only 385 participants in 15 months⁴.
13 Subsequently, the program was expanded by the Massachusetts Department of Public Health
14 and has trained over 12,000 people in the state. Over 1300 successful reversals have been
15 documented through 2012^{5,6}; and
16
- 17 Whereas, Population analysis from the Boston community-bystander overdose educational and
18 naloxone program has demonstrated lower rates of overdose death in towns with over 150
19 individuals trained in the use of intranasal naloxone per 100,000 people⁷; and
20
- 21 Whereas, Other state medical societies including, but not limited to, New York⁸ and North
22 Carolina⁹ have already supported efforts to reduce mortality from drug overdoses by making
23 naloxone more available; and
24
- 25 Whereas, A number of policy hurdles to expanding the life-saving use of naloxone exist, but
26 precedent to overcome these hurdles already exists¹⁰; and
27
- 28 Whereas, Naloxone is a prescription drug and therefore subject to the general laws and
29 regulations that govern all prescriptions; and
30
- 31 Whereas, Intranasal use of naloxone is off label, but the safe use of intranasal naloxone has
32 been well studied^{11,12,13,14}, confirmed in randomized trials^{15,16}, and is the standard of care in
33 many local communities¹⁷; and
34
- 35 Whereas, Intranasal naloxone is cost effective, at a unit price of approximately \$20, and
36 covered by many insurance providers^{18,19}; and
37
- 38 Whereas, Prescribing intranasal naloxone to any patient at risk for opioid overdose is fully
39 compliant with state and federal laws regulating drug prescribing²⁰; and

1 Whereas, Patients at risk for opioid overdose include, but are not limited to, patients who (a)
2 have received emergency medical care for opioid intoxication, (b) have a suspected or admitted
3 history of substance abuse or nonmedical opioid use, (c) have recently been released from
4 opioid detoxification, abstinence programs, or incarceration, (d) are prescribed methadone or
5 buprenorphine, (e) use high-dose (>50mg morphine equivalent per day) opioids, (f) have rotated
6 from one opioid to another, (g) have comorbidities including HIV/AIDS, respiratory, renal,
7 hepatic, and cardiac disease, (h) concurrently smoke, use alcohol, sedatives, and/or
8 antidepressants, (i) may have difficulty accessing emergency medical services (distance or
9 remoteness)^{21,22,23,24}

10
11 Whereas, Educating patients and caregivers in the signs and symptoms of opioid overdose, and
12 the use of naloxone in the reversal of opioid overdose is legal and appropriate¹³; and

13
14 Whereas, Naloxone is already widely used in the prehospital setting without the direct
15 supervision of a physician. Several states and municipalities, including New Mexico,
16 Connecticut, New York, and San Francisco, have already approved the use of naloxone by non-
17 medical personnel in the first-aid setting, resulting in at least 900 drug overdose reversals in
18 less than 10 years²⁵; and

19
20 Whereas, The prescription status of naloxone prohibits its administration to a person other than
21 for whom it was prescribed; however, naloxone may be administered to a person at risk by
22 family, friend, or bystander in the same way that an EpiPen® or glucagon injection may be
23 administered to someone with anaphylaxis or low blood sugar who is unable to administer the
24 medication themselves¹²; therefore, be it

25
26 RESOLVED, That our AMA support the use of nasal naloxone by medical first responders and
27 trained non-medical personnel for the life-saving reversal of opioid overdose; and, be it further

28
29 RESOLVED, That our AMA advocate for the routine education of all patients receiving
30 prescription opioids, all patients at risk for opioid overdose, and their caregivers in the signs and
31 symptoms of opioid overdose, and the use of nasal naloxone in the reversal of opioid overdose;
32 and, be it further

33
34 RESOLVED, That our AMA advocate for the routine prescription of nasal naloxone to all
35 patients at risk for opioid overdose.

Fiscal Note: Less than \$500

Relevant AMA Policy

D-95.987 Intranasal Naloxone Administration

Our AMA: (1) recognizes the great burden that opiate addiction and abuse places on patients and society alike and reaffirms its support for the compassionate treatment of patients with opiate addiction; and (2) will monitor the progress of intranasal naloxone studies and report back as needed. (Res. 526, A-06)

H-95.990 Drug Abuse Related to Prescribing Practices

1B. 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. (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)

H-95.954 The Reduction of Medical and Public Health Consequences of Drug Abuse

Our AMA: (1) encourages national policy-makers to pursue an approach to the problem of drug abuse aimed at preventing the initiation of drug use, aiding those who wish to cease drug use, and diminishing the adverse consequences of drug use;

(2) encourages policy-makers to recognize the importance of screening for alcohol and other drug use in a variety of settings, and to broaden their concept of addiction treatment to embrace a continuum of modalities and goals, including appropriate measures of harm reduction, which can be made available and accessible to enhance positive treatment outcomes for patients and society;

(3) encourages the expansion of opioid maintenance programs so that opioid maintenance therapy can be available for any individual who applies and for whom the treatment is suitable. Training must be available so that an adequate number of physicians are prepared to provide treatment. Program regulations should be strengthened so that treatment is driven by patient needs, medical judgment, and drug rehabilitation concerns. Treatment goals should acknowledge the benefits of abstinence from drug use, or degrees of relative drug use reduction;

(4) encourages the extensive application of needle and syringe exchange and distribution programs and the modification of restrictive laws and regulations concerning the sale and possession of needles and syringes to maximize the availability of sterile syringes and needles, while ensuring continued reimbursement for medically necessary needles and syringes. The need for such programs and modification of laws and regulations is urgent, considering the contribution of injection drug use to the epidemic of HIV infection;

(5) encourages the undertaking of comprehensive research into the potential effects, both positive and adverse, of relaxing existing drug prohibitions and controls and, that, until the findings of such research can be adequately assessed, the AMA reaffirm its opposition to drug legalization;

(6) strongly supports the ability of physicians to prescribe syringes and needles to patients with injection drug addiction in conjunction with addiction counseling in order to help prevent the transmission of contagious diseases; and

(7) encourages state medical associations to work with state regulators to remove any remaining barriers to permit physicians to prescribe needles for patients. (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10)

¹ Centers for Disease Control and Prevention (CDC). Vital signs: overdoses of prescription opioid pain relievers—United States, 1999–2008. MMWR Morbidity Mortality Weekly Report. 2011; 60(43):1487-1492.

² CDC. WONDER [Database]. Atlanta, GA: US Department of Health and Human Services, CDC; 2012. Available at <http://wonder.cdc.gov>. Accessed February 13, 2012.

³ Warner M, Chen L, Makuc D, Anderson R, Miniño A. Drug poisoning deaths in the United States, 1980-2008. NCHS Data Brief: National Center for Health Statistics; 2011, No.81. Available at www.cdc.gov/nchs/data/databriefs/db81.pdf. Accessed February 13, 2012.

⁴ Doe-Simkins M, Walley AY, Epstein A, Moyer, P. Saved by the nose: bystander-administered intranasal naloxone hydrochloride for opioid overdose. American Journal of Public Health. 2009; 99(5): 788-791.

⁵ Jancin B. Bystander-given naloxone may reverse opioid overdose. Rheumatology News. 2011 Feb; 50. Available at <http://intranasal.net/OpiateOverdose/IN%20naloxone%20Rheumatology%20news%2020111.pdf>. Accessed February 13, 2012.

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- ⁶ Walley A – Assistant Professor of Medicine, Boston University Medical Center. Personal communication, March 14, 2012.
- ⁷ Walley AY, Xuan Z, Hackman H, et al. Implementation and evaluation of Massachusetts' overdose education and naloxone distribution program. Oral session presented at: the 139th Annual Meeting of the American Public Health Association. Washington, D.C.:November 1, 2011.
- ⁸ Medical Society of the State of New York. Position Statements 2011. Preventing overdose deaths – community-based naloxone programs: 65.992 Available at www.mssny.org/mssnycfm/mssnyeditor/File/2011/About/Position_Statements/2011_Position_Statements.pdf. Accessed February 13, 2012.
- ⁹ North Carolina Medical Board. Position Statements. Drug overdose prevention. Created 9/1/08. Available at www.ncmedboard.org/position_statements/detail/drug_overdose_prevention/ Accessed February 12, 2012.
- ¹⁰ Burris S, Beletsky L, Castagna C, Coyle C, Crowe C, McLaughlin J. Stopping an invisible epidemic: legal issues in the provision of naloxone to prevent opioid overdose. *Drexel L Rev* 2009;1:273–340.
- ¹¹ Ashton H, Hassan Z. Intranasal naloxone in suspected opioid overdose. *Emergency Medicine Journal*. 2006 March; 23(3): 221-223.
- ¹² Barton ED, Colwell CB, Wolfe T, Fosnocht D, Gravitz C, Bryan T, Dunn W, Benson J, Baily J. Efficacy of intranasal naloxone as a needleless alternative for treatment of opioid overdose in the prehospital setting. *Journal of Emergency Medicine*. 2005 Oct; 29(3): 265-271.
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AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 5
(A-12)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Reducing Barriers that Limit Specialty and Subspecialty Choice for Osteopathic Graduates

Referred to: Reference Committee

WHEREAS, The Accreditation Council for Graduate Medical Education (ACGME) has recently proposed a major revision to the “Common Program Requirements”¹, stating: *“Prerequisite clinical education for entry into ACGME-accredited residency programs must be accomplished in ACGME-accredited residency programs or Royal College of Physician and Surgeons of Canada (RCPSC)-accredited residency programs located in Canada”* (Section III.A.2)²

WHEREAS, Similar changes have been proposed for qualifications to enter an ACGME-accredited fellowship program.

WHEREAS, The ACGME has estimated that this policy would affect approximately 1.1% of current US resident physicians and 6.9% of US fellowship applicants if it were to be implemented this year.²

WHEREAS, This new policy does not permit interns who have completed a residency solely accredited by the American Osteopathic Association to enroll in an ACGME-accredited residency or fellowship program for their advanced years of clinical training (i.e. PGY-2 year and beyond).

WHEREAS, State laws in Florida, Michigan, Oklahoma, and Pennsylvania require a Doctor of Osteopathic Medicine (DO) to complete an AOA-accredited internship in order to practice medicine in his or her state.³

WHEREAS, There are relatively few dual-accredited ACGME and AOA internships and residency programs offered to osteopathic graduates (who wish to continue osteopathic training either for educational benefit or to comply with state law).

WHEREAS, The American Osteopathic Association has expressed concern that this policy change will “deprive the public of well trained physicians” and “disrupt a system of graduate medical education that has worked well for trainers, training programs and the public we service for more than 40 years”.¹

WHEREAS, Under this new policy, residency and fellowship program directors from ACGME-accredited programs will no longer be permitted to offer positions to highly qualified osteopathic applicants.³

WHEREAS, This policy would impact all fellowship programs and any residency program in a specialty that recruits residents with advanced standing, including

Anesthesiology, Dermatology, Neurology, Ophthalmology, Physical Medicine and Rehabilitation, Psychiatry, Radiology, and Radiation Oncology.

WHEREAS, Our AMA has adopted policy to explore the feasibility of collaborating with stakeholder organizations to explore opportunities to align educational policies and practices (D-295.326; CME Rep 12, A-09).

WHEREAS, In the absence of any changes to the proposed new ACGME policy III.A.2, it will become effective July 1, 2014.³ Therefore, be it

RESOLVED, That our AMA collaborate with stakeholder organizations, including the Accreditation Council for Graduate Medical Education (ACGME), to reduce barriers that limit resident physicians with osteopathic training from entering the specialty or subspecialty of their choice; and be it further

RESOLVED, That our AMA reaffirm its recognition of the value of both doctors of allopathic medicine (MD) and doctors of osteopathic medicine (DO) within the physician workforce (including all medical specialties and subspecialties), and oppose policies that arbitrarily limit career decisions for either of these groups.

Fiscal Note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 6
(A-12)

Introduced by: Raphael Yechieli MD, Michael Ehler MD, M. Salim Siddiqui MD, PhD,
Michigan Delegation

Subject: Oncofertility and Fertility Preservation Treatment

Referred to: Reference Committee

-
- 1 WHEREAS, Approximately 70,000 adolescents and young adults (AYA) between the ages of 15
2 and 39 years of age will be diagnosed with cancer this year¹; and
3
4 WHEREAS, The risk of infertility due to cancer therapy should be discussed with all cancer
5 patients at the time of diagnosis and fertility preservation therapy should be an essential part in
6 the management of AYAs with cancer, and referral for fertility preservation should be made
7 within 24 hours^{2,3}; and
8
9 WHEREAS, 34-72% of patients are counseled about the risk of iatrogenic infertility from cancer
10 treatment, only 2-4% of patients pursue fertility preservation⁴; and
11
12 WHEREAS, Insurance will not routinely cover payments for fertility preservation treatments,
13 even in states with mandated infertility coverage⁵; therefore be it
14
15 RESOLVED, That our AMA support payment for standard fertility preservation by all payers when
16 iatrogenic infertility may be caused, directly or indirectly, by medical treatments necessitated as
17 determined by a licensed physician; and be it further
18
19 RESOLVED, That our AMA lobby for appropriate legislation requiring payment for fertility
20 preservation therapy services when iatrogenic infertility may be caused, directly or indirectly, by
21 medical treatments necessitated as determined by a licensed physician; and be it further
22
23 RESOLVED, That this resolution be immediately forwarded to the House of Delegates.

Fiscal Note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 7
(A-12)

Introduced by: Alik Widge, University of Washington ; Katherine Harvey, Harvard School of Public Health ; Ricardo Correa, University of Miami ; Sara Dyrstad, Washington University in St. Louis ; Rashmi Kudesia, New York Presbyterian Hospital ; Nicole Lee, University of Mississippi ; David Paz, Community Health Network (Indiana) ; Amber Sabbatini, University of Chicago ; Ryan Van Woerkom, Oregon Health & Sciences University

Subject: Physician Stewardship of Health System Resources

Referred to: Reference Committee

WHEREAS, Cost of health care continues to rise unsustainably, and the US spends more per capita than other developed nations without significant gains in health outcomes^{1, 2, 3,4}; and

WHEREAS, Both monetary and physical (practice space, equipment, labor, and supplies) resources for health care are finite; and

WHEREAS, There are many inefficiencies in the current health system, including, but not limited to, fragmentation of care, duplication of tests, overuse and misuse of diagnostic studies, avoidable hospitalizations, re-hospitalizations, and regional variations in cost of care^{1,5}; and

WHEREAS, The increasing cost of medical care is financially burdening US households⁶; and

WHEREAS, There is increasing momentum among medical societies for physicians to be prudent stewards of health care resources, including preventing antibiotic overuse and avoiding unnecessary procedures, as highlighted in the ACP's High-Value Cost-Conscious Care Initiative and ABIM Foundation's "Choosing Wisely" campaign^{7,8,9,10,11,12,13,,14}; and

WHEREAS, Physicians on the front lines are often not aware of the true costs of their medical decisions due to opaque and byzantine billing and reimbursement, as well as a failure of medical education to teach trainees about the costs of their medical decision making^{13, 15}; and

WHEREAS, Practice habits developed during medical school, residency and fellowship tend to persist throughout a physician's career¹⁶; and

WHEREAS, In order to provide high-value, evidenced-based care, trainees must learn throughout our educations how to balance the costs of care with the individual needs of their patients^{13,15,17}; therefore be it

RESOLVED, That it is the position of our AMA-RFS that physicians have an ethical duty to be responsible stewards of health system resources and should seek to practice cost-conscious medicine when feasible while maintaining the primacy of the patient's best interests; and be it further

RESOLVED, That our AMA-RFS support and encourage efforts by academic institutions and accrediting bodies to improve residents' and fellows' education regarding cost-conscious medicine.

Fiscal Note: Less than \$500

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RELEVANT AMA Policy

H-295.924 Future Directions for Socioeconomic Education

The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that

survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum. (CME Rep. 1-I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-295.977 Socioeconomic Education for Medical Students

1. The AMA favors (a) continued monitoring of U.S. medical school curricula and (b) providing encouragement and assistance to medical school administrators to include or maintain material on health care economics in medical school curricula. 2. Our AMA will advocate that the medical school curriculum include an optional course on coding and billing structure, RBRVS, RUC, CPT and ICD-9. (CME Rep. B, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 318, A-10)

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

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 RESIDENT AND FELLOW SECTION

Resolution: 8
(A-12)

Introduced by: Sion Roy, MD (Vice-chair California Medical Association RFS)

Subject: Health Policy Elective Rotation

Referred to: Reference Committee on Medical Education

- 1 WHEREAS, Encouraging a more active membership remains a goal of the AMA; and
2
3 WHEREAS, Recruiting young physician members in creative new ways is necessary for the AMA
4 to maintain it's ability to achieve it's worthy goals; and
5
6 WHEREAS, Educating student, resident, and fellow members about health policy remains a
7 goal of the AMA; and
8
9 WHEREAS, local chapters of the AMA, including the California Medical Association, have
10 explored creating health care policy elective rotations; and
11
12 WHEREAS, these local chapters have faced barriers to funding these rotations. Therefore, be it
13
14 RESOLVED, That the AMA will study and report back on how to best help state medical
15 societies develop health policy elective rotations for interested students, residents, and fellows;
16 and be it further
17
18 RESOLVED, That the AMA advise state medical societies on how to set up educational goals
19 and objectives, a curriculum, and develop faculty mentorship; and be it further
20
21 RESOLVED, That the AMA will advise societies on how to work with academic institutions to
22 recruit participants and on how to fundraise for this purpose.

Fiscal Note: \$5,000

RELEVANT AMA-RFS AND AMA POLICY

295.986R

Health Policy Education in Medical School and Residency: That our AMA work with interested organizations to develop and incorporate a health policy curriculum into medical school and residency training that is based on a list of core topics integral to the fundamental understanding of health policy. (Resolution 5, I-11)

H-295.924 Future Directions for Socioeconomic Education

The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that

survey teams pay close attention during the accreditation process to the degree to which "socioeconomic" subjects are covered in the medical curriculum. (CME Rep. 1-I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-440.969 Meeting Public Health Care Needs Through Health Professions Education

(1) Faculties of programs of health professions education should be responsive to the expectations of the public in regard to the practice of health professions. Faculties should consider the variety of practice circumstances in which new professionals will practice. Faculties should add curriculum segments to ensure that graduates are cognizant of the services that various health care professionals and alternative delivery systems provide. Because of the dominant role of public bodies in setting the standards for practice, courses on health policy are appropriate for health professions education. Additionally, governing boards of programs of education for the health professions, as well as the boards of the institutions in which these programs are frequently located, should ensure that programs respond to changing societal needs. Health professions educators should be involved in the education of the public regarding health matters. Programs of health professions education should continue to provide care to patients regardless of the patient's ability to pay and they should continue to cooperate in programs designed to provide health practitioners in medically underserved areas. (2) Faculty and administrators of health professions education programs should participate in efforts to establish public policy in regard to health professions education. Educators from the health professions should collaborate with health providers and practitioners in efforts to guide the development of public policy on health care and health professions education. (BOT Rep. NN, A-87; Reaffirmed: CSA Rep. 8, A-05)

H-295.977 Socioeconomic Education for Medical Students

1. The AMA favors (a) continued monitoring of U.S. medical school curricula and (b) providing encouragement and assistance to medical school administrators to include or maintain material on health care economics in medical school curricula. 2. Our AMA will advocate that the medical school curriculum include an optional course on coding and billing structure, RBRVS, RUC, CPT and ICD-9. (CME Rep. B, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 318, A-10)

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

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)

H-460.971 Support for Training of Biomedical Scientists and Health Care Researchers

Our AMA: (1) continues its strong support for the Medical Scientists Training Program's stated mission goals; (2) supports taking immediate steps to enhance the continuation and adequate funding for stipends in federal research training programs in the biomedical sciences and health care research, including training of combined MD and PhD, biomedical PhD, and post-doctoral (post MD and post PhD) research trainees; (3) supports monitoring federal funding levels in this area and being prepared to provide testimony in support of these and other programs to enhance the training of biomedical scientists and health care research; (4) supports a comprehensive strategy to increase the number of physician-scientists by: (a) emphasizing the importance of biomedical research for the health of our population; (b) supporting the need for career opportunities in biomedical research early during medical school and in residency training; (c) advocating National Institutes of Health support for the career development of physician-scientists; and (d) encouraging academic medical institutions to develop faculty paths supportive of successful careers in medical research; and (5) supports strategies for federal government-sponsored programs, including reduction of education-acquired debt, to encourage training of physician-scientists for biomedical research. (Res. 93, I-88; Reaffirmed: Sunset Report, I-98; Amended: Sub. Res. 302, I-99; Appended: Res. 515 and Reaffirmation A-00; Reaffirmed: CME Rep. 14, A-09)

H-295.922 Establishing Essential Requirements for Medical Education in Substance Abuse

AMA policy states that alcohol and other drug abuse education needs to be an integral part of medical education; and that the AMA supports the development of programs to train medical students in the identification, treatment, and prevention of alcoholism and other chemical dependencies. Our AMA: (1) asks all residency review committees to review their training requirements in the treatment and management of substance abuse and addiction and to make recommendations for strengthening this provision as needed; and (2) encourages the development of specialty-specific needs assessment to determine whether targeted educational activities in substance abuse would be useful in their overall program of continuing medical education (Res. 303, I-94; Reaffirmed and Appended: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)

H-310.911 ACGME Allotted Time Off for Health Care Advocacy and Health Policy Activities

Our AMA: 1) urges the Accreditation Council for Graduate Medical Education (ACGME) to acknowledge that "activities in organized medicine" facilitate competency in professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice; 2) encourages residency and fellowship programs to support their residents and fellows in their involvement in and pursuit of leadership in organized medicine; and 3) encourages the ACGME and other regulatory bodies to adopt policy that resident and fellow physicians be allotted additional time, beyond scheduled vacation, for scholarly activity time and activities of organized medicine, including but not limited to, health care advocacy and health policy. (Res. 317, A-11)

H-310.929 Principles for Graduate Medical Education

[Principle 10]:

(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 9
(A-12)

Introduced by: Medical Society of the State of New York Resident and Fellow Section

Subject: AMA Interim Meeting: Shorten by One Day

Referred to: Reference Committee

1 WHEREAS, Our AMA Interim and Annual Meetings are a substantial budget item for our AMA;
2 and
3
4 WHEREAS, Many state and specialty societies struggle to provide funding to send their
5 Delegates to AMA meetings; and
6
7 WHEREAS, The use of virtual Reference Committees allows many more AMA members to
8 participate in the discussion of resolutions and potentially allows for AMA business to be
9 conducted in a shorter period of time; and
10
11 WHEREAS, The Opening Session of our AMA Interim Meeting is reserved mainly for speeches
12 and awards, occupying an entire day of business at the expense of fiscal responsibility;
13 Therefore be it
14
15 RESOLVED, That our AMA shorten the AMA Interim Meeting by one day, initiating live
16 Reference Committee sessions on Saturday and concluding business on Monday, as a means
17 to conserve the resources of both our AMA and individual state and specialty societies.
18
19 Fiscal Note: TBD

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Resolution: 10
(A-12)

Introduced by: Massachusetts Medical Society – Resident and Fellow Section

Subject: Evaluating the effect of ACGME resident-work hours reforms

Referred to: Reference Committee

- 1 Whereas, the Accreditation Council for Graduate Medical Education (ACGME) implemented
2 new resident work hour rules in July 2011; and
3
- 4 Whereas, our American Medical Associate (AMA) encouraged the ACGME to not adopt the
5 Institute of Medicine’s (IOM) recommendation for protected sleep periods which could have
6 significant unintended consequences for continuity of patient care and safety, until research
7 shows improved patient care and safety¹; and
8
- 9 Whereas, it is our duty as the AMA-RFS to monitor resident working conditions, including
10 working hours, and report back to the Assembly as appropriate; and
11
- 12 Whereas, our AMA supports that the structuring of duty hours and on-call schedules must focus
13 on the needs of the patient, continuity of care, and the educational needs of the resident²; and
14
- 15 Whereas, our AMA has resolved to continue to work with the ACGME to further refine the
16 standards for resident physician duty hours and to collect additional evidence on the impact of
17 the current standards with respect to preserving the quality of resident physician education and
18 eliminating fatigue and sleep deprivation³; and
19
- 20 Whereas, our AMA policy states that as continued evidence is developed and collected
21 regarding resident work hours, patient safety, resident well-being, and resident education,
22 resident physician total duty hours shall be reassessed⁴; and
23
- 24 Whereas, our AMA is authorized to use existing policy as a guideline in working with state
25 medical societies to obtain modification to total residency work hours, conditions and
26 supervision⁵; and
27
- 28 Whereas, members of the Massachusetts Medical Society Resident and Fellow Section,
29 conducted a survey of residents and fellows in the state of Massachusetts regarding the effects
30 of the new ACGME work hour rules (Appendix 1); and
31
- 32 Whereas, the survey was completed by 100 residents from multiple specialties across a range
33 of training levels (Appendix 1); and
34
- 35 Whereas, the survey found 71% of all respondents to be dissatisfied with the new ACGME work
36 hour rules; and
37
- 38 Whereas, the survey found 73% of all respondents to be dissatisfied with the new 16 hour limit
39 for interns; and
40

1 Whereas, the survey found 43% of all respondents to face scheduling difficulties due to the limit
2 of six consecutive nights during night float; and
3

4 Whereas, other frequent and/or pertinent complaints included a) reduced patient care due to
5 frequent hand offs b) chronic fatigue due to an increased number of shifts to compensate for
6 reduced hours c) decreased opportunities to participate in procedures for surgical specialties in
7 particular and other specialties in general d) reduced patient ownership by residents and interns
8 e) poor understanding of a patient's clinical trajectory due to frequent hand offs f) the six night
9 limit forces programs to pull a trainee for 1 night to cover the last night of the week that causes
10 rapid change in the sleep cycle for the covering trainee and increases the number of weekends
11 they are required to work g) junior trainees are working in conditions that are very different from
12 conditions they will be expected to work in as fellows and attendings; therefore be it
13

14 RESOLVED, that our AMA recognize the potential risks associated with the new ACGME
15 resident work hours rules to include: reduced continuity of care due to frequent hand offs,
16 chronic fatigue due to an increased number of shifts, decreased opportunities to participate in
17 procedures for surgical specialties, and junior trainees working in conditions that are very
18 different from conditions they will be expected to work in as fellows and attendings; and be it
19 further
20

21 RESOLVED, that our AMA study the impact of the new ACGME resident duty hour standards,
22 including as they relate to the learning environment, and monitor relevant research on duty
23 hours, sleep, and resident and patient safety, with a report back no later than the 2013 Annual
24 Meeting of the AMA House of Delegates; and be it further
25

26 RESOLVED, that our AMA urge the ACGME, AAMC and/or other relevant and interested bodies
27 to study these issues nationwide; and be it further
28

29 RESOLVED, that our AMA recommends the ACGME to assess the impact of the recently
30 introduced resident duty hour rules and to introduce new rules only if they are evidence-based;
31 and be it further
32

33 RESOLVED, this be forward to the AMA House of Delegates immediately.

Fiscal Note: Less than \$1000

1. D-310.955 Resident/Fellow Duty Hours, Quality of Physician Training, and Patient Safety Our AMA will call for pilot programs and further research into protected sleep periods during prolonged in-house call and, until such research shows improved patient care and safety, will encourage the ACGME to not adopt the IOM report's call for a protected sleep period, which could have significant unintended consequences for continuity of patient care and safety, as well as being difficult and expensive to implement and monitor.

2. H-310.957 Resident Working Conditions Reform Update: (1) Our AMA supports the following new language pertaining to resident work hours and environment for the "General Requirements" of the "Essentials of Accredited Residencies in Graduate Medical Education": Each residency program must establish formal policies governing resident duty hours and working environment that are optimal for both resident education and the care of patients. (a) Special requirements relating to duty hours and on-call schedules shall be based on an educational rationale and patient need, including continuity of care. (b) The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that residents are provided backup support when patient care responsibilities are especially difficult or prolonged. (c) Resident duty hours and on-call schedules must not be excessive. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hours must be consistent with the General and Special Requirements that apply to each program. Detailed structuring of resident service is an integral part of the approval

process and therefore close adherence to the General and Special Requirements is essential to program accreditation. (2) Our AMA supports the following proposed revision of the "Special Requirements" for surgery: It is desirable that residents' work schedule be designed so that on the average, excluding exceptional patient care needs, residents have at least one day out of seven free of routine responsibilities and be on-call in the hospital no more often than every third night. The ratio of hours worked and on-call time will vary, particularly at the senior levels, and therefore necessitates flexibility. (BOT Rep. YY, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CME Rep. 2, A-11)

3. D-310.986 Accreditation Council for Graduate Medical Education Enforcement of Duty Hour Standards: Our AMA will: (a) continue to work with the ACGME to further refine the standards for resident physician duty hours and to collect additional evidence on the impact of the current standards with respect to preserving the quality of resident physician education and eliminating fatigue and sleep deprivation.

4. D-310.989 Resident Physician Working Conditions: (1) As continued evidence is developed and collected regarding resident work hours, patient safety, resident well-being, and resident education, resident physician total duty hours shall be reassessed.

5. H-310.963 Residency/Fellowship Working Hours and Supervision: It is the policy of the AMA (1) to continue to work with the Accreditation Council for Graduate Medical Education to implement AMA policy for residency work hours reform; and (2) to use existing policy as a guideline in working with state medical societies and medical specialties to obtain modification, if needed, of pending and future legislation on or changes to total residency work hours, conditions and supervision. (Sub. Res. 191, I-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10)

Additional AMA Policy

H-310.927 Resident Physician Working Conditions

(1) Our AMA adopts the following definitions for resident physician education: (a) "Total duty hours" represents those scheduled hours of activity associated with a residency program and include: (i) scheduled time providing direct patient care or supervised patient care that contributes to the ability of the resident physician to meet educational goals and objectives; (ii) scheduled time to participate in formal educational activities, (iii) scheduled time providing administrative and patient care services of limited or no educational value, and (iv) time needed to transfer the care of patients; and (b) "Organized educational activities" are of two types: (i) "Formal educational activities" include scheduled educational programs such as conferences, seminars, and grand rounds and (ii) "Patient care educational activities" include individualized instruction with a more senior resident or attending physician and teaching rounds with an attending physician.

(2) Resident physician total duty hours must not exceed 80 hours per week, averaged over a two-week period and that our AMA work with GME accrediting bodies to determine if an increase of 5% may be appropriate for some training programs.

(3) Workdays that exceed 12 hours are defined as on-call.

(4) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for up to 30 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.

(5) On-call shall be no more frequent than every third night and there be at least one consecutive 24-hour duty-free period every seven days both averaged over a two-week period.

(6) On-call from home shall be counted in the calculation of total duty hours and on-call frequency if the resident physician can routinely expect to get less than eight hours of sleep.

(7) There should be a duty-free interval of at least 10 hours prior to returning to duty.

(8) Limits on total duty hours must not adversely impact resident physician participation in the organized educational activities of the residency program. Formal educational activities must be scheduled and available within total duty hour limits for all resident physicians for at least eight hours per week averaged

over a two-week period.

(9) Scheduled time providing patient care services of limited or no educational value be minimized

(10) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work. (CME Rep. 9, A-02)

H-310.928 Resident/Fellow Work and Learning Environment

1. Our AMA may draft original, modify existing, or oppose legislation and pursue any regulatory or administrative strategies when dealing with resident work hours and conditions.

2. Our AMA will oppose any efforts by the federal government, including the Department of Labor's Occupational Safety and Health Administration, to regulate resident education and training, including resident and fellow duty hours. (Res. 310, I-01; Reaffirmed: Res. 322, A-03; Appended: Res. 219, I-10)

H-310.918 Resident and Duty Hours: A Review of the Institute of Medicine Recommendations

Our AMA supports: (1) current duty hour requirements as set forth in the Common Program Requirements, Accreditation Council for Graduate Medical Education, Section VI; and (2) additional study of the issues raised with respect to duty hours in the IOM report and consider further modifications of the current duty hours requirements based on the results of this inquiry. (Res. 327, A-09)

D-310.991 Intern and Resident Working Hours

The ACGME: (1) through its Residency Review Committees (RRC) and the Institutional Review Committee, enforce work hour guidelines rigorously and ensure compliance with work hour standards; and (2) be requested to investigate mechanisms to provide readily accessible, timely and accurate information about work hours for individual programs that is not constrained by the cycle of survey visits. (CME Rep. 1, I-01; Reaffirmed: CME Rep. 2, A-11)

D-310.964 Enforcement of Duty Hours Standards and Improving Resident, Fellow and Patient Safety
Our AMA:

1. Reaffirms support of the current Accreditation Council for Graduate Medical Education duty hour standards.

2. Continues to monitor the enforcement and impact of the ACGME duty hour standards, as they relate to the larger issue of the optimal learning environment for residents, and will monitor relevant research on duty hours, sleep, and resident and patient safety, with a report back at the 2010 Annual Meeting of the AMA House of Delegates.

3. Will, as part of its Initiative to Transform Medical Education strategic focus, utilize relevant evidence on patient safety and sleep to develop a learning environment model that optimizes balance between resident education, patient care, quality and safety, and report back at the 2010 Annual Meeting.

4. Will review, evaluate, and publicize the work of the ACGME Committee on Innovation, in particular its pilot projects related to duty hours, and will encourage participation by ACGME Residency Review Committees and residency programs in these and other efforts towards innovation and improvement in graduate medical education and patient safety.

5. Will ask the ACGME to consider offering programs/institutions additional incentives, such as longer accreditation cycles or reduced accreditation fees, to ensure programmatic and institutional compliance with duty hour limits.

6. Encourages publication of studies about the effects of duty hour standards, extended work shifts, hand offs and continuity of care procedures, and sleep deprivation and fatigue on patient safety, medical error, resident well-being, and resident learning outcomes, and will disseminate study results to GME designated institutional officials (DIOs), program directors, resident/fellow physicians, attending faculty, and others.

7. Will communicate to all GME DIOs, program directors, resident/fellow physicians, and attending faculty

about the importance of accurate, honest, and complete reporting of resident duty hours as an essential element of medical professionalism and ethics.

8. Will use the GME e-Letter, AMA Resident and Fellow Section publications, and other communications vehicles to raise awareness among residents (particularly first-year residents) of the ACGME and its role in monitoring and enforcing duty hours.

9. Council on Medical Education will closely monitor the progress of the Institute of Medicine (IOM) committee studying resident duty hours and patient safety and to respond, and/or assist the AMA Washington Office in responding, to any legislative or regulatory initiatives that arise from the IOM or other bodies.

10. Urges the ACGME and AOA to decrease the barriers to reporting duty violations and resident intimidation. (CME Rep. 5, A-08)

D-310.978 Enforcement of ACGME Duty Hours Standards

Our AMA will:

(1) continue to monitor the enforcement of the Accreditation Council for Graduate Medical Education duty hour standards, including the consistency, accuracy, and validity of reporting, and report back at the 2006 Annual Meeting;

(2) work with other interested groups to assist residency programs in educating resident physicians and attending faculty about the adverse effects of sleep deprivation and fatigue on patient safety and resident well-being;

(3) strongly encourage Residency Review Committees to ensure that site visits include meetings with peer-selected or randomly-selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor;

(4) recommend to the ACGME that the Common Program Requirements be amended to charge program directors, along with the designated institutional official, with the responsibility of creating an environment where resident physicians, without fear of retaliation, may make complaints and report noncompliance with ACGME standards, including duty hours;

(5) investigate ways to protect resident physicians who file a complaint to the ACGME, and report back at the 2006 Annual Meeting; and

(6) encourage and disseminate the results of studies that link compliance with duty hour standards to patient care quality outcomes and patient safety. (CME Rep. 1, I-04)

D-310.973 Enforcement of ACGME Duty Hour

Our AMA will:

(1) Continue to monitor the enforcement and impact of the Accreditation Council for Graduate Medical Education duty hour standards, as they relate to the larger issues of optimal patient care and learning environment for residents, with a report back at the 2008 Annual Meeting of the AMA House of Delegates.

(2) Encourage and disseminate the results of studies that link compliance with duty hours standards to patient care quality and medical errors, as well as to resident learning and professionalism.

(3) Work with other interested groups to regularly inform GME designated institutional officials (DIOs), program directors, resident physicians, and attending faculty about the adverse effects of sleep deprivation and fatigue on patient safety and resident well-being.

(4) Work with the ACGME to improve the reporting mechanisms for duty hour violations in order to better protect resident confidentiality and improve the learning environment. (CME Rep. 4, A-06)

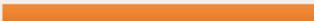
ACGME WORK HOUR RULES SURVEY MASSACHUSETTS MEDICAL SOCIETY RESIDENT AND FELLOW SECTION

1. What year of training are you in (PGY level)?		Create Chart	Download
		Response Percent	Response Count
PGY 1		25.0%	25
PGY 2		28.0%	28
PGY 3		28.0%	28
PGY 4		7.0%	7
PGY 5		8.0%	8
PGY 6		1.0%	1
PGY 7 or higher		3.0%	3
		answered question	100
		skipped question	0

2. What speciality are you training in?		Download
		Response Count
		Show Responses
		100
		answered question
		100
		skipped question
		0

Internal Medicine and related sub-specialities: 67/100
 Surgery and related sub-specialities: 11/100
 Pediatrics and related sub-specialities: 06/100
 Radiology: 09/100
 Neurology: 03/100
 Physical Medicine and Rehabilitation: 02/100
 Emergency Medicine: 02/100

3. How many residents in your training program are in the call pool?		Download
		Response Count
	Show Responses	100
	answered question	100
	skipped question	0

4. Do you create the call schedule for residents in your program?		Create Chart	Download
		Response Percent	Response Count
Yes		13.0%	13
No		87.0%	87
	answered question		100
	skipped question		0

5. Does the stipulation for no more than six consecutive nights in the hospital create scheduling difficulties for the seventh night?		Create Chart	Download
		Response Percent	Response Count
Yes, it creates scheduling difficulties only for me personally		0.0%	0
Yes, it creates scheduling difficulties only for our program		15.0%	15
Yes, it creates scheduling difficulties for both myself as well as our program		28.0%	28
No		57.0%	57
	Comments (please specify) Show Responses		12
	answered question		100
	skipped question		0

COMMENTS:

Juniors and Interns on ambulatory rotations are being pulled to work those nights

3/28/2012 10:14 AM

Do you mean 6 consecutive days in the hospital with 1 day off? Yes that is a problem for continuity of care. As good as pass offs are, there is still some information that cannot be passed off such as how a patient looks, whether they look sick, other subjective data, etc.

3/26/2012 6:57 PM

Intern and junior residents are required to cover these 7th nights from there outpatient and consult rotations

3/23/2012 11:59 AM

Juniors have had to cover intern level jobs.

3/20/2012 10:50 PM

Juniors are pulled from elective or outpatient rotation to cover interns on the 7th night.

3/20/2012 6:37 PM

That's more of something for our chiefs, but the seventh night is usually covered by another resident.

3/20/2012 3:06 PM

it also compromises patient care, leads to many medical errors due to bad hand offs, and this has not been well studied at all. It is dangerous. Residents no longer know their patients and provide suboptimal care

3/20/2012 2:28 PM

This is a non-evidence-based arbitrary decision, and should at least allow 7 nights in a row.

3/20/2012 2:00 PM

We are not in danger of going over work week hours. Now instead of just doing a 7 day week of night float we have to cover a night float shift at a different time in the yr. rotating thru differently timed shift work at a quick pace is difficult. Additionally we lose an weekend off by covering that shift (a wkend is already ruined with 6 night float nights in a row better to just tag the 7th night onto that).

3/19/2012 7:02 PM

Need to work 7 days if we do 1-week shifts

3/19/2012 6:59 PM

Don't know

3/12/2012 9:45 AM

When on night float, we have six days on and three off, so we know it won't always overlap with a weekend. We also have enough residents to cover.

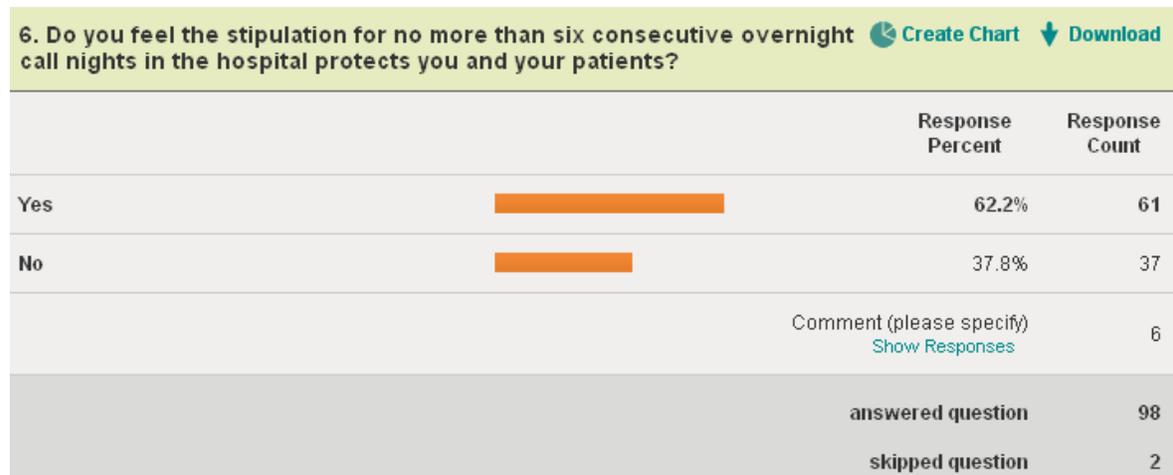
3/10/2012 6:17 PM

N/A--no call in the ED

3/9/2012 6:49 PM

Cannot do 1 continuous week of night float, inconvenient to find coverage for 7th day since we take call by week

3/9/2012 1:57 PM



COMMENTS:

But seven would not be too different.

4/5/2012 6:10 AM

We do not have any consecutive nights in the hospital.

3/27/2012 5:11 PM

I think this has made patients less safe. With all of the hand offs, no one on the primary teams knows the patients any more.

3/26/2012 6:57 PM

But I think there needs to be more creative solutions.

3/20/2012 6:37 PM

it leads to more medical errors and less patient satisfaction

3/20/2012 2:28 PM

Namely the residents because it allows for some protected time off

3/20/2012 1:54 PM

N/A

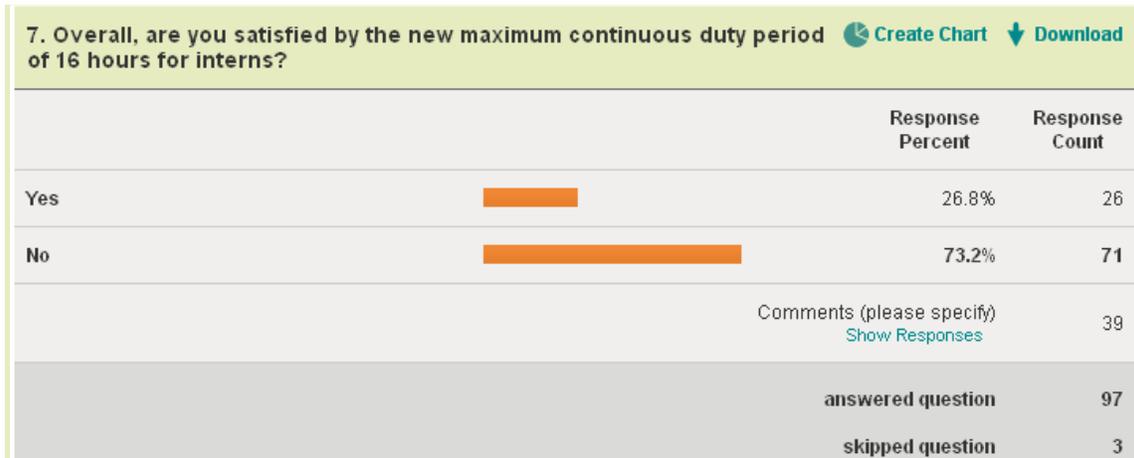
3/20/2012 8:53 AM

More tired by switching sleep schedules to cover that extra night at a different time

3/19/2012 7:02 PM

Honestly, by the 6th night in a row, I personally feel compromised in my ability to provide outstanding patient care, and I worry that patient safety could be adversely impacted due to sleep deprivation.

3/9/2012 2:16 PM



COMMENTS:

Think it should be 20. This is the best balance between avoiding excessive fatigue and providing continuity/better care/better education

4/5/2012 6:10 AM

The only huge exception is on some services you will typically work 12-16+ hours every day for six consecutive days at a time (ongoing for several weeks), which lends itself to a different kind of fatigue.

3/28/2012 10:30 AM

It has a negative effect on training and leads to worse patient care in providers starting out in clinical care who need more time to think about and get to know their patients.

3/28/2012 10:14 AM

Has significantly decreased patient continuity of care and created several opportunities for errors given frequent passoffs

3/28/2012 9:09 AM

I think it's a lot healthier for the interns; that said, it doesn't give them the experience of being on call, and a lot of the overflow work gets shuffled off onto those who are one level higher than them instead.

3/27/2012 5:11 PM

I think this has made patients less safe. With all of the hand offs, no one on the primary teams knows the patients any more.

3/26/2012 6:57 PM

This had a very negative impact on the contribution interns could provide on the service, it also forced us to incorporate them in ways that are much more restrictive and overall led to what they complained as a poorer quality of life

3/26/2012 4:07 PM

Too short. Increased pass-offs. Decreased intern ownership of patients.

3/23/2012 11:59 AM

Since continuous hrs are limited to 16 hrs but weekly hours are still limited to 80, this leads to more overall fatigue. Quality of life is also decreased significantly as there is virtually no time outside of the hospital during normal business hours. I don't know if there is any hard data yet but I suspect error rates and patient care quality have gone down due to the increased number of passoffs and requirement that the same max number of admissions be done in a shorter period of time (e.g. 5 admissions in 16 hrs vs. 5 admissions in 24 hrs before).

3/23/2012 8:48 AM

difficult to do the same amount of work (i.e. admissions) in a shorter period of time. you end up leaving before initial labs/work-up come back and miss the crucial part of a patient's presentation in the first 24 hours.

3/22/2012 9:21 PM

The interns do not know patients well and handoffs are challenging

3/21/2012 9:12 PM

The change is so significant that it has been hard to adapt and re-organize the program. In addition, 16hrs shifts are disrupting patient care and fragmenting the learning experience of residents. They are not able to be there for full discussions of their patients, have poor follow-up on their clinical decision-making when they are on the night shift. Their inability to take call means that they have more frequent "long days" which they say gives them worsening quality of life over all.

3/21/2012 2:11 PM

Challenging to appropriately manage new admissions in the shorter time period, increased time spent on hand offs

3/21/2012 2:55 AM

really long hours EVERY day, still 80 total. PGY-2 and higher are covering for interns.

3/21/2012 12:37 AM

creates more handoffs and compromises learning

3/21/2012 12:14 AM

24 hours is more reasonable. 16 goes too far. Interns are in the hospital all the time with just short breaks for sleep because of the new rule. Never any early days. Juniors/seniors stuck late to supervise pass-offs.

3/20/2012 6:37 PM

The interns end up working numerous long days in a row, which is more exhausting than Q4 call.

3/20/2012 6:16 PM

Pointless rule that makes it very difficult to come up with a reasonable schedule and takes away the post-call day off, resulting in worse cumulative fatigue.

3/20/2012 4:18 PM

interns know the patients less and don't end up getting more sleep or rest.

3/20/2012 3:18 PM

Yes. For the safety of my patients, I prefer my inexperience not be compounded by the equivalent of several alcoholic drinks.

3/20/2012 3:06 PM

I think it should be 12 hours, not 16 hours.

3/20/2012 3:06 PM

decreased continuity of care, loss of team due to various nightfloat roles, less learning

3/20/2012 2:43 PM

No, I think that we have not studied well the impact of the changes that we are making. We are basing a lot of the changes on one study with a lot of limitations that was conducted at one hospital. We don't know what we are doing and I see the changes cause compromise in patient care every single day!

3/20/2012 2:28 PM

decreased quality of care, increased handoffs, less autonomy and understanding of the patients. Interns actually seem more tired as in the hospital more overall and less time off in a row as far as their quality of life. Care transitioned to junior residents who are still there for 24/30 hours

3/20/2012 1:58 PM

Disrupts continuity and makes the hours we are on less efficient and more stressful with higher chances for errors; it's as if we're set up to be the least effective, most uninformed versions of ourselves

3/20/2012 1:54 PM

It's created really long days, chaos, handoffs that are unsafe

3/20/2012 1:54 PM

Decreased overall hours without increased manpower to overcome the deficit

3/20/2012 1:53 PM

No, I believe that it has harmed both education objectives of training and overall patient care. I think that by forcing a night float model on interns, the ACGME has prevented continuity over that first critical period of admission, the beginning. Accepting patients from night float I never feel that I know as well as if I admitted them myself. Furthermore, in not seeing the initial clinical trajectory, it is hard to know how patients have improved, gotten worse, or gotten better from admission. Finally, it severely limits any teaching around new admissions if there is to be any continuity of care in the patients who are already on the list.

3/20/2012 1:43 PM

It doesn't affect me, but I feel it creates scheduling problems.

3/20/2012 11:05 AM

N/A

3/20/2012 8:53 AM

I had to work more than 16 hours as an intern, and didn't feel that >16 hours resulted in suboptimal care for patients. During my surgical internship, I worked close to 80 hours on several weeks.

3/19/2012 9:25 PM

Not applicable

3/19/2012 6:55 PM

less continuity of care, no post call days, it just ends up being more long days instead of post call and getting off work at reasonable times in the evening. the interns always end up working super late...

3/15/2012 10:20 PM

I feel these new rules are adversely affecting patient care and intern education. As a result the interns have become shift workers who no longer follow their new patient's course through the beginning of their stay, are disconnected from the team, and frequently miss learning opportunities as they have to go home before rounds frequently. Additionally the increased number of hand offs as a result of the new rules mean that no one on the team really knows the patient well and I have found many important clinical issues missed on patients as a result.

3/12/2012 5:01 PM

I feel it limits patient care continuity and makes for many more pass offs.

3/12/2012 9:45 AM

16 seems like an arbitrary number, and it's not "clean" like 12 hours would be for a shift system. If they worked the full sixteen hours, this could lead to them getting out at a late hour of the night and be at higher risk for adverse commuting events.

3/10/2012 6:17 PM

Continuity of care has a tendency to be compromised with the increased number of sign-outs and handing off of patients..

3/10/2012 5:07 PM

Though to be honest it does not affect our program that much because I am in an advanced residency program.

3/10/2012 4:55 PM

I have admit the same number of patients in less time

3/10/2012 11:50 AM

In our specialty, we don't have interns, so this is not applicable.

3/10/2012 9:00 AM

doesn't affect me since the most junior residents in an anesthesia program are PGY2

3/10/2012 7:37 AM

While it does not affect our ED coverage, it creates many transition staffing challenges as interns go from the ED to other services or vice versa

3/9/2012 6:49 PM

It creates a mentality of shift work, and there is no longer an implicit sense of ownership and responsibility for patient care.

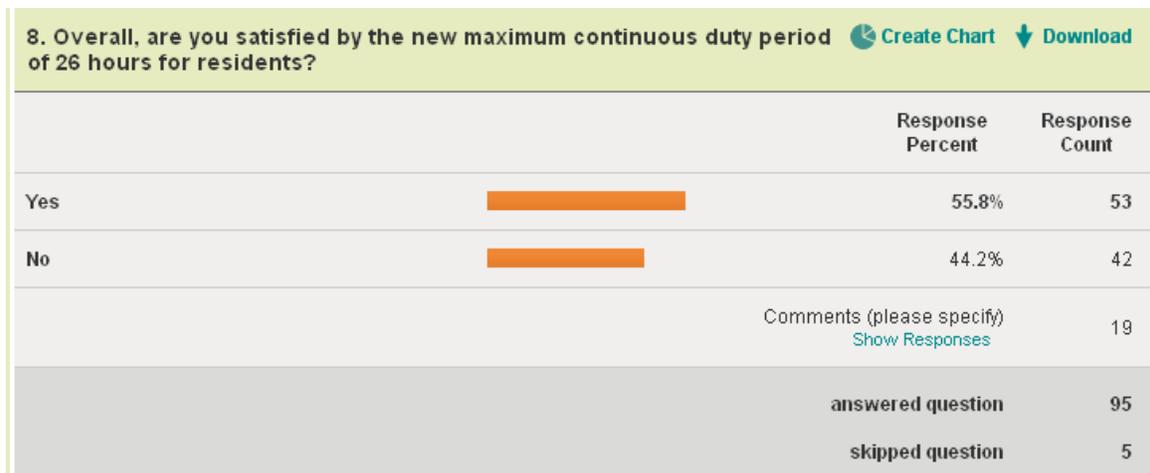
3/9/2012 2:16 PM

It does not effect my program as interns do not take call.

3/9/2012 1:26 PM

Although an intern is the youngest member of a team but forcing each individual intern to only be able to stay in house 16 hours we are inadvertently treating each of them as weaker team members.

3/9/2012 1:22 PM



COMMENTS:

N/A

3/28/2012 10:30 AM

24-30 hours is probably fine. There is no reason that residents are better at this than interns, and in fact it is interns that need the experience and the time to better take care of their patients.

3/28/2012 10:14 AM

It's not really reasonable to have a 26 hr maximum: you come in and round, and by the time you're done rounding the next day it's very difficult to get all the work and patient care done in the ~1 hr you then have left. The prior system worked better.

3/27/2012 5:11 PM

Any stringency in this matter can prevent surgical residents from participating in patient care activities (such as cases) in which there would be significant learning benefit. I think having the rule in place is great, but exceptions abound and the rules do not permit for these.

3/26/2012 5:31 PM

There is now more need to supervise interns and there is not enough time to transition care

3/21/2012 9:12 PM

Many of our PGY-2 rotations are still structured as 30-hour calls, with no attempts to limit it to 26-28 hours.

3/21/2012 9:45 AM

Not happening while interns are only working 16

3/21/2012 12:37 AM

Not much different from 30.

3/20/2012 6:37 PM

It's too long!

3/20/2012 3:06 PM

same as above

3/20/2012 2:28 PM

Not applicable because I am an intern

3/20/2012 1:26 PM

I suppose so. During residency, I worked up to 30 hours continuously during ICU rotations.

3/19/2012 9:25 PM

Not applicable

3/19/2012 6:55 PM

Those who are going to go over because the structure of the system are going to go over. In medicine, for example, after you're the team on call, you know you really need to tie up all the loose ends yourself before you leave because you know the on-call team has their own patients and admissions coming in and can't run around doing your busywork for your patients.

3/10/2012 6:17 PM

I think it is too short to include patient hand-off and rounding on our own patients.

3/10/2012 4:55 PM

I thought it was 28! (24 hours new pt care + 4 hours pass-off)

3/10/2012 7:37 AM

28h (not 26)

3/9/2012 6:12 PM

it does not make sense that interns are capped at 16hrs but they can work 26hrs the next year

3/9/2012 4:16 PM

should be fewer

3/9/2012 3:38 PM

N/A. I'm an intern.

3/9/2012 2:29 PM

This does not apply, rule is 16

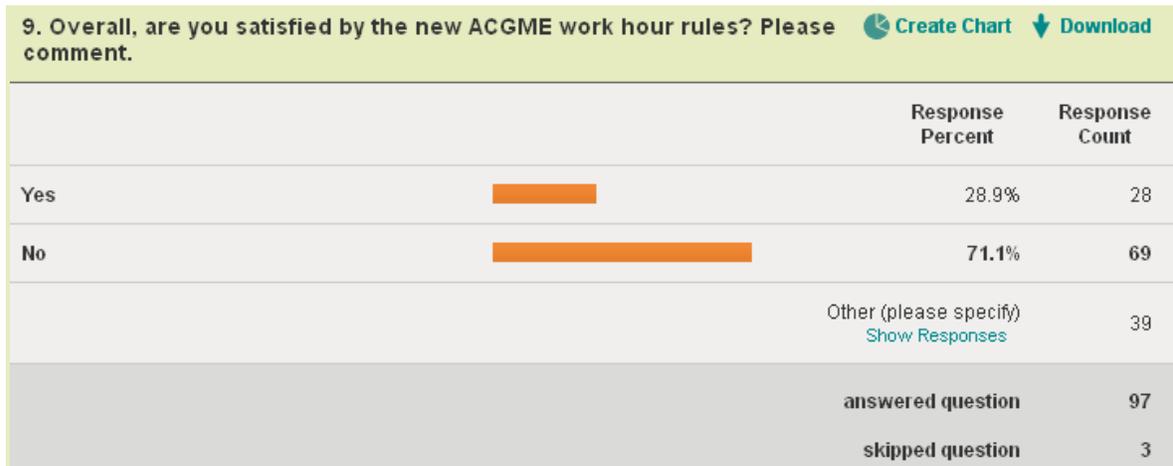
3/9/2012 1:38 PM

At times there are patients you would like to see post call past 26 hours. It is understandable not to see new patients, but we should be able to see patient for follow up.

3/9/2012 1:26 PM

This still creates problems with awareness and ability to perform. It's an unrealistic expectation for any human being, academic achievements notwithstanding, to function at full capacity after 24 hours of constant, often high pressure work, and to be able to provide the care necessary and assume the responsibility for other people's well being

3/9/2012 1:25 PM



COMMENTS:

16 hour rule is too short.

4/5/2012 6:10 AM

But a program must be able to properly to: 1. Staff inpatient floors appropriately accordingly to patient volume. 2. Place appropriate inpatient admission/consult volume caps. I believe that without these in place, patient safety and provider quality of life take huge hits.

3/28/2012 10:30 AM

It is an intervention based on limited evidence and political pressure that has a very negative effect on medical training and what I believe is also a negative effect on patient care.

3/28/2012 10:14 AM

It is absurd that interns/residents are working less than the fellows and attendings they are training to become

3/28/2012 9:09 AM

I think they are well-intentioned, but that without extender staff or vastly expanding programs, there just aren't enough people in many programs to make them reasonable.

3/27/2012 5:11 PM

The new work hours rules have created a culture of shift work where house staff no longer know anything about their patients. As consultants, we hear "I don't know about the patient, it was just signed out to me to call you" about 80% of the time. I would not want to be cared for in that manner and I don't think that is how we should be caring for our patients.

3/26/2012 6:57 PM

when training as a surgeon, we need more time in the hospital. the new work hours mean the interns are not learning to operate. they get to be third years and can barely do what they used to do as interns.

3/26/2012 5:01 PM

The rules particularly affecting interns have only shifted and concentrated the responsibility to the PGY2 residents. This has impacted their ability to learn in the operating rooms and has negatively impacted their operative logs, their overall satisfaction, and the coverage of procedures on our service.

3/26/2012 4:07 PM

It does lead to more hand-offs so there is more dependence on the fellows and faculty for continuity.

3/23/2012 12:34 AM

I have only seen downside from the new work hour requirements.

3/23/2012 11:59 AM

I did Q4H overnight call as a medical student and I think it provides better continuity and knowledge of your patients. How are interns and PGY-2 that different in their sleep needs? I think it was fine the way it was prior to the 16 hour rule.

3/22/2012 9:21 PM

The work-hours have significantly reduced the amount of didactic teaching time and dramatically increased the amount of time spent in pass offs. The vast number of pass offs required threatens patient care, patient-physician relationships, and patient safety much more than fatigue ever did in my experience. The fact that most patients have 3 responsible physicians during the critical 24 hours after admission threatens their care and dramatically impairs the ability of interns to learn from the admission process. The key diagnostic and therapeutic decisions, immediate follow up, and continuing care that happens during this period -- which involves a tremendous amount of learning by experience -- is divided. Medicine residents are now a lot like emergency medicine doctors -- decisions and treatment plans made, with much more limited follow-up on outcome than they have traditionally had. I do not feel this year's crop of interns is anywhere near the level of ability that the current 2nd-year residents were at this time in the year and will not be really ready to assume the much greater responsibilities traditionally accorded second year residents in our program come July. Patients advocacy groups should be screaming in outrage over the catastrophic effects of that have resulted from implementing this untested, unproven and theoretical intervention.

3/21/2012 6:55 AM

- poor patient continuity - resident and intern dissatisfaction - decreased learning time - interns actually work longer more frequently, with less consolidated time off

3/21/2012 12:37 AM

pendulum has swung too far, and new work hours increase the percentage of time devoted to handoffs, decrease learning opportunities, increases potential for handoff-related errors, and does not actually reduce overall intern hours, so chronic fatigue is still an issue

3/21/2012 12:14 AM

where is the data?

3/20/2012 10:50 PM

See above

3/20/2012 6:37 PM

We are losing a great deal in terms of educational value of residents seeing a lot of pathology in the hospital without any clear benefit in terms of safety, patient outcomes, or resident satisfaction.

3/20/2012 3:18 PM

I think there is a practical and philosophical disconnect between the aim to limit sleep deprivation and the minimum of 8 hours off between shifts. I believe it would be in the interest of patient safety and resident education if there were a mandated 9-10 hours off between shifts.

3/20/2012 3:06 PM

I feel like I never get a day off. We need more staffing at MGH

3/20/2012 3:06 PM

I think the ACGME has been extremely immature in their recommendations, very rash, and not scientific in their calculations. In the pursuit of balancing education and service, we are simply creating less competent doctors and one day 10 years from now, we will hear all about this. We will remember the days when we created a generation of doctors that are unable to take care of their patients. Thank you ACGME

3/20/2012 2:28 PM

There is simply more fractured care, without any improvement in overall patient care or resident quality of life.

3/20/2012 2:00 PM

problems with the PGY-1 rule

3/20/2012 1:58 PM

I wish we could still work the 26 hour shifts because it enhanced continuity and education

3/20/2012 1:54 PM

24 hours is perfectly ok.

3/20/2012 1:54 PM

Unreasonable to mandate fewer work hours while solely expecting increased efficiency (already maxed out my most residencies) and no increase in compensated manpower

3/20/2012 1:53 PM

I believe that the data behind them is quite limited and that the changes were made by people out of touch with the logistics of inpatient medical care. While I do not know that an intern needs to take 30-hour shifts, 24 is a very reasonable expectation, and cutting it less than that has not improved my restfulness (having experienced the longer call cycle as a medical student), directly

inhibited my learning, and probably worsened overall care for my patients because of decreased continuity of care. In speaking with nearly every one of my colleagues, we would much prefer the opportunity to take 24-hour call as interns.

3/20/2012 1:43 PM

Night float is more effective when longer block can be scheduled, allowing an adjustment period. Shortening this to 6 consecutive nights or less is detrimental

3/20/2012 11:05 AM

As a post resident who went through the 30 hour max on call it was definitely hard but our program protected us from getting out on time and it was important for learning to see evolution of disease processes. I do not feel 16 hours for interns is sufficient to all of a sudden expect them to be ready for resident status with 26 hour call.

3/20/2012 9:18 AM

I don't understand why the work hour rules are continuously revised. The resultant intern experience is "lighter", and these young physicians have less clinical experience to draw upon in their later resident years. With the continued work hour changes, residencies will almost have to increase in time (years) in order for residents to have a full complement of cases and experiences.

3/19/2012 9:25 PM

No 7 nights in a row is a scheduling issue

3/19/2012 7:02 PM

As long as they change the 6-day rule

3/19/2012 6:59 PM

I would rather do 7 consecutive nights of night float than have to take a random night to be on nightfloat. The latter is more disruptive to my sleep schedule.

3/19/2012 6:55 PM

please see my above comments on the issues regarding the 16 hour rule for interns.

3/12/2012 5:01 PM

I feel that our program is doing a great job meeting the new restrictions but it makes scheduling very difficult in that you are on the day call some days and nights others. Sleep becomes very fragmented .

3/12/2012 9:45 AM

There really isn't data on these changes and their long-term effects. Also, handoffs are a *huge* issue. With shorter shifts, there's an increasing mentality of "someone else will take care of it". Similar to the bystander effect (the more people are standing around something bad happening, the less likely they are to actually report it).

3/10/2012 6:17 PM

As an intern posted in the MICU in particular, it becomes physically taxing to be expected to be in the hospital by 530 am every day (to get a good grip on overnight events of all patients, particularly in winter when the census runs high and rounds begin sharp at 830 AM).

3/10/2012 5:07 PM

Aside from my comment above in question 8, I think the rules have worked out fine.

3/10/2012 4:55 PM

See above!

3/10/2012 11:50 AM

Actually in radiology these work hours have never been an issue even before publication of the new rules.

3/10/2012 9:00 AM

Overall satisfied, but as more people move toward night-float systems, more thought needs to go into not over burdening the residents.

3/10/2012 7:37 AM

Arbitrary distinction between interns and residents max duty hours. Favor a max shift length of 24 hours.

3/9/2012 11:27 PM

regulations should be stricter for senior residents

3/9/2012 3:38 PM

My biggest issue is with the way medicine now feels like shift work, with very little time spent at the bedside and very little invested emotional attachment to patients as a direct result of this shift work mentality.

3/9/2012 2:16 PM

Honestly, the answers to my survey are not going to be helpful as it is darn near impossible to break the work hour rules in my program/specialty.

3/9/2012 1:32 PM

It is almost impossible to train a person in my field with the current restrictions we have. Although it is suppose to create more time for reading and studying and "resting" I actually believe I am accomplishing less. I have to commute to and from the hospital much more frequently and if I am at the hospital I am constantly working and do not have any time to read or study. Before when I was able to spend more time in the hospital I was able to both work and read.

3/9/2012 1:22 PM

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report E
(A-12)

Introduced by: RFS Council on Long Range Planning

Subject: Green Initiative

Referred to: Reference Committee

I. Introduction

At Annual 2011, the *Paperless Meeting* resolution was adopted with resolved clauses instructing that our AMA-RFS plan a true “green” or “paperless” meeting in a pilot project for I-11, including no pre-printed handbooks, online-only updates and surveys, and minimal paper handouts. This resolution also instructed the AMA-RFS to conduct an on-line exit survey after completion of I-11 to determine if the practice of paperless meetings is a feasible option for the AMA-RFS and work to increase “green” initiatives by the AMA-RFS.

II. Background

At Interim-11 in New Orleans, an online Paperless Meeting Survey was administered through the online website SurveyMonkey and released to attendees of the I-11 meeting on Saturday 11/12/11, towards the latter half of the business session. Prior to Interim-11, there were multiple emails through the RFS communications group account and website postings to alert RFS members of the paperless meeting plans at I-11 with recommendations to download the material posted online. A couple weeks prior to I-11, CLRP also sent individual emails to each Region Chair reminding them of the paperless meeting pilot at I-11. Several copies of the Reference Committee report were printed for each Region; otherwise the RFS I-11 meeting was paperless.

III. Results

The survey was open for one week following I-11. At the close of the survey, a total of 44 people responded to the 7 question, electronic Paperless Meeting survey (See Appendix A) out of 153 attendees (29% response rate).

- 45.5% of responders (20 people) indicated that they had been to 3 or more AMA-RFS meetings, with 27.3% of people indicating that this was their first meeting (12 people). *Question 1*
- 97.7% of responders (43 people) indicated that they brought a laptop or notebook computer with internet access. *Question 2*
- 77.3% of responders (34 people) had a “smart” phone with internet access. 15.9% of responders had paper printouts of AMA-RFS materials such as resolutions, candidate statements, etc. *Question 2*
- 27.3% of responders (12 people) indicated that they were unaware of the paperless meeting pilot prior to the meeting. *Question 3*
- 47.7% of responders (21 people) felt that the overall Interim 2011 meeting would have been neither better nor worse if printed materials had been available. *Question 4*

- 1 • When asked which items would be preferred in paper format, 50% (22 people) indicated the
2 schedule of the meeting agenda, 36.4% (16 people) indicated late/emergent resolutions, and
3 34.1% (15 people) indicated Reference Committee reports. *Question 5a*
- 4 • 61.4% of responders (27 people) indicated that they would not require printed paper for future
5 meetings. 34.1% (15 people) indicated that they would like paper materials but were unlikely to
6 pay for them. *Question 6*

7 The final and optional survey question asked for additional comments regarding the paperless meeting
8 pilot project and they were more positive than negative (see appendix A). Comments suggesting future
9 modifications included having: some paper copies of the reference committee reports (enough for 1-2 per
10 state); individual or separate pdf files for easy access to materials; small note pads or something else for
11 people to do real-time work; separating the pdf handbook by chapters; and having the schedule available
12 in paper form or enlarged outside the door.

13 14 **III. Discussion**

15
16 After evaluating the survey results in which 44 AMA-RFS members responded, CLRP felt that the
17 majority of the survey responders were aware of the paperless meeting pilot at I-11 prior to coming to the
18 meeting and that the majority of responders did not require printed paper handouts for future meetings.
19 After evaluating survey question 5 addressing which material should be prepared in paper form, CLRP
20 felt the items that responders preferred to have in paper form included: 1.) Schedule of the meeting
21 agenda, 2.) Late and/or emergency resolutions, and 3.) Reference Committee reports. CLRP also felt that
22 as more people gain mobile internet access, the need for the currently recommended minimal paper
23 handouts at future meetings may change and/or decline. Reassessment of this need for minimal paper
24 handouts at future meetings may prove to be beneficial.

25
26 A limitation of these results is that only a minority of attendees responded to the survey despite multiple
27 verbal and email reminders. The CLRP cannot exclude the possibility that certain categories of attendees
28 (e.g., those attending the meeting in conjunction with the research symposium) may have been less likely
29 to be aware of the pilot project and to respond to the survey. However, the breakdown of responses to
30 Question 1 (see Appendix A) are suggestive of a fairly representative sample with substantial
31 representation of first-time attendees, those who had attended a few meetings, and those who had
32 attended multiple meetings.

33 34 **IV. RECOMMENDATIONS:**

35
36 After evaluating the Paperless Meeting Pilot at I-11 with an electronic survey, the CLRP recommends:

- 37
38 1. That the AMA-RFS continue the “green” or “paperless” format at future meetings when feasible,
39 including online-only updates and surveys, limited pre-printed handbooks, and several paper copies per
40 Region of the meeting agenda/schedule, late and/or emergent resolutions, and Reference Committee
41 reports.
42
- 43 2. That the AMA-RFS continue to work toward the goal of a paperless meeting.

Appendix A

RFS Paperless meeting

1. How many AMA-RFS interim and annual meetings have you attended, including this one?

		Response Percent	Response Count
A. This is my first meeting		27.3%	12
B. 2-3		27.3%	12
C. 3 or more		45.5%	20
		answered question	44
		skipped question	0

2. Which of the following did you bring with you to the meeting? (Please select all that apply.)

		Response Percent	Response Count
A. Laptop or notebook computer with Internet access		97.7%	43
B. "Smart" phone with Internet access		77.3%	34
C. Paper printouts of AMA-RFS materials such as resolutions, candidate statements, etc.		15.9%	7
D. None of the above		0.0%	0
		answered question	44
		skipped question	0

3. At this meeting, materials including candidate statements, AMA bylaws, committee reports, and resolutions were not prepared in paper form. Were you aware of this policy prior to coming to the meeting?

		Response Percent	Response Count
A. Yes		72.7%	32
B. No		27.3%	12
		answered question	44
		skipped question	0

4. Thinking about the Interim 2011 meeting as a whole, if printed paper materials had been available at the meeting, do you think this would have made your overall experience:

		Response Percent	Response Count
A. Much better		6.8%	3
B. A little better		18.2%	8
C. Neither better nor worse		47.7%	21
D. A little worse		18.2%	8
E. A lot worse		9.1%	4
		answered question	44
		skipped question	0

5. Which if any of the following do you think should be prepared in paper form for future AMA-RFS national meetings? Please select all that apply.

		Response Percent	Response Count
A. AMA-RFS bylaws		0.0%	0
B. Schedule of meeting agenda		50.0%	22
C. Maps of the meeting site		20.5%	9
D. Personal statements/curriculum vitae of candidates for elected positions		0.0%	0
E. Standard resolutions and committee reports (printed in the online meeting handbook)		18.2%	8
F. Late and/or emergency resolutions (not printed in the online meeting handbook)		36.4%	16
G. Reference Committee reports (prepared during the meeting)		34.1%	15
H. I don't think any of these should be prepared in paper form (i.e., a "paperless" meeting)		27.3%	12
		answered question	44
		skipped question	0

6. If printed materials were available upon request at future meetings, would you be willing to pay a nominal fee for this material to offset the costs of printing, recycling, etc.?

		Response Percent	Response Count
A. No, I do not require printed paper materials for meetings.		61.4%	27
B. No, I would like paper materials but am unlikely to pay for them.		34.1%	15
C. Yes, I would like paper materials and am willing to pay a nominal fee for them		4.5%	2
		answered question	44
		skipped question	0

7. Do you have any additional comments about the “paperless meeting” pilot project at Interim 2011 or printed materials for future national meetings? (optional)

	Response Count
Hide Responses	18

Anonymous Responses:

- If the handbook pdf had chapters so as to easily jump to sections, this would be greatly appreciated and limit the extensive use of scrolling. I believe that schedule and resolutions/reports are the most often used and vital bits of information to refer to during the meeting. Having chapters for these and having them prioritized at the top of the document may be helpful. (all for going paperless, would just like to make tweaks as we move forward to make things easier. fully support this movement).
- I liked the paperless.
- Loved it. Would have liked to have had electronic balloting including pictures of the candidates. Also, would have liked to have had emergency resolutions emailed out. Also, making it clear ahead of time that the conference would be paperless would have been nice.
- I think the schedule should at least be available in paper form or enlarged outside the door. I think it would make things easier so you can just glance at the schedule instead of having to take time to look it up online.
- I love this initiative to be more environmentally responsible
- More than one refcom report per region, please!
- I think it was a success, however, if in the future voting for candidates could go online that would also be an improvement.
- This meeting proves there is no need for paper. Not once did I even notice that I was only looking at the materials online (which I greatly prefer) until it was brought up Saturday morning. Hopefully this superior form or media distribution can result in a significant cost savings to the AMA and RFS.
- I don't require paper copies though I'd like an individual or 2 separate pdf files for easy access to materials I refer to most often.
- Advertise a little more before the meeting that it will be wireless, so attendees are aware.
- Wireless worked well, but this has not always been the case in previous meetings. Additionally, if the HOD wants to expand on this, they must have better HOD-level wireless.

- notify participants of paperless meeting ahead of time, can give a cd of all the documents to all participants for ease of use, and this would be cheaper than paper.
- I splurged for an iPad so all of my meetings can be paperless.
- While I think this was a nice idea, I think it hindered the process considerably and negatively impacted first-time attendees
- The one thing we do need: small note pads or something else for people to scribble testimony, write notes, or generally do just a little bit of real-time work. Laptops are not up to that yet.
- At least have some paper copies of the reference committee reports (enough for 1-2 per state).
- Keep it paperless!

I.

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: F
(A-12)

Introduced by: RFS Council on Long Range Planning
Subject: GME Delegates
Referred to: Reference Committee

1 **I. Introduction**
2

3 At the 2011 Annual Meeting of the American Medical Association Resident and Fellow
4 Section (AMA-RFS), the Assembly adopted Report G, "Making At-Large Delegate
5 Positions Permanent" (Appendix B). This report amended the AMA-RFS Internal
6 Operating Procedure (IOP) to include the newly-created and piloted At-Large Delegate
7 position as an option for RFS members to become Delegates at RFS Assembly
8 Meetings. Report G noted several barriers to serving in the AMA-RFS Assembly for
9 both first time attendees and more seasoned members and that the creation of At-Large
10 positions would help to reduce those barriers. At-Large Delegate positions were piloted
11 in 2010 and the success of the pilot was detailed in Report G, which was adopted to
12 make the At-Large Delegate position a permanent part of the RFS Assembly. The
13 AMA-RFS Council on Long Range Planning (CLRP) believes that by adding GME
14 Delegate spots, barriers to participation will continue to be reduced and the Assembly
15 will continue to grow and become more representative of its constituency.
16

17 **II. Background**
18

19 When Assembly participation declined from an average of 140 participants prior to 2006
20 to as few as 76 in 2008, Governing Council members and AMA staff began to look more
21 critically at potential barriers and new opportunities for involvement. In light of declining
22 participation, questions were raised if the RFS Assembly was still representative of its
23 peers and if the associated financial expenditures were justifiable.
24

25 Specialty societies were given proportional representation in the RFS Assembly at the
26 2009 RFS Annual Meeting, and the Assembly grew significantly (Assembly attendance
27 rose from an average of 76 in 2008 to an average of 121 in 2009). For informational
28 purposes, the number of registered attendees at the Annual and Interim meetings from
29 A-05 through I-11 is provided below.
30

31 AMA-RFS Registered attendees:

32
33 A-05: 141
34 I-05: 161
35
36 A-06: 144
37 I-06: 201
38
39 A-07: 104

1	I-07:	136
2		
3	A-08:	48
4	I-08:	104
5		
6	A-09:	119 (Specialty Representation Implemented)
7	I-09:	123
8		
9	A-10:	135
10	I-10:	156
11		
12	A-11:	101
13	I-11:	153

14
15 While the implementation of specialty society representation resulted in an increase in
16 attendees, it did not fully address several barriers that RFS members faced in attending
17 Assembly meetings. State and specialty societies have always been encouraged to fill
18 all their allotted seats, but many do not due to economic restraints or other reasons. In
19 addition, it appears that some states and specialties do not even offer or promote these
20 opportunities to their resident and fellow members. Even in the states that do offer
21 funding, some residents and fellows who relocate to those states during training have
22 faced imposing barriers to climbing up their new state's leadership structure quickly
23 enough to obtain endorsement and remain active in the RFS Assembly.

24
25 The At-Large Delegate pilot program was implemented at I-10. For the I-10 meeting, the
26 RFS had three At-Large applicants. One of those At-Large Delegates ran for, and was
27 elected to, an Alternate Sectional Delegate position at the meeting. He has since
28 obtained an endorsement from his state to serve as an RFS Sectional Delegate in the
29 HOD. Although there were only three people who applied for At-Large Delegate
30 positions, many should have been placed into these positions during credentialing. In
31 fact, there were 27 people that were credentialed onsite that neither received
32 endorsement from their state or specialty nor registered for the meeting. Therefore,
33 these 27 individuals, which include some long-standing participants, should have been
34 considered At-Large members but they were allowed to credential as representatives of
35 states or specialties that had unfilled seats.

36
37 The number of At-Large Delegates increased to seven at A-11, and then to fifteen at I-
38 11. Many of the I-11 At-Large Delegates were Research Symposium participants who,
39 because of the At-Large program, were able to participate in the Assembly and
40 experience the full range of activities at an RFS meeting for the first time.

41
42 As demonstrated in Appendix C, there still remains minimal resident and fellow
43 participation in the RFS Assembly from several states and specialties. The RFS
44 delegation is broken down by state and specialty, number of available delegate seats
45 (excluding the corresponding number of alternate delegate seats) allotted to each
46 state/specialty for I-11, the number of delegate seats (excluding the corresponding
47 number of alternate delegate seats) officially filled by that state or specialty at I-11, and
48 the number of poster participants (most of whom credentialed onsite) who were placed
49 in unfilled positions once the At-Delegate positions were filled. The state in which each

1 At-Large Delegate that participated in the I-11 meeting lives is also shown in Appendix C
2 (corresponding specialty society information for these participants was not collected).

3 4 **III. Discussion**

5
6 During the discussion of Report G, several methods for increasing participation in the
7 RFS Assembly were proposed, including the creation of Delegate seats through
8 Graduate Medical Education (GME) programs. The RFS Council on Long Range
9 Planning (CLRP) evaluated the current outreach efforts of the RFS with regards to
10 Assembly growth and decided to explore the potential impact of recruiting new RFS
11 Assembly members of both large and small GME programs directly through their GME
12 institutions.

13
14 Providing GME institutions with representation in the RFS Assembly would address
15 several barriers to participation that RFS members face. Some GME institutions have
16 expressed a willingness to allot time off to, and fund, their residents and fellows in order
17 to attend RFS meetings as their representative. Since the AMA already has established
18 relationships with several GME institutions, there may be a natural pool of programs
19 through which to initially recruit. Furthermore, institutions that have not historically
20 approved time-off or funding for their residents and fellows to attend the RFS meeting
21 may be more compelled to do so if granted direct representation.

22
23 Representation for GME institutions would also provide another avenue for residents
24 who are not involved in their state and specialty societies to become involved in the RFS
25 Assembly. While the At-Large Delegate position has further addressed barriers to
26 participation, it is important to note that all fifteen of the available At-Large Delegate
27 positions for I-11 were filled. To continue to grow the participation in the RFS Assembly,
28 further avenues for participation and potential funding sources should be identified.

29
30 In order to consider piloting GME institution representation in the RFS Assembly, the
31 RFS-CLRP would first have to draft a report proposing several alternatives for selecting
32 which institutions should be given representation, the method for allocating
33 representation, and potential effect on the Assembly.

34 35 **IV. Summary**

36
37 To continue to have a positive and meaningful impact on our healthcare system, it is
38 essential for the AMA-RFS to continue to evaluate and modulate the accessible routes
39 for residents and fellows to actively participate in the RFS Section and make the
40 Assembly a more representative and thriving body. With upcoming changes drastically
41 affecting health care in the United States (including implementation of the Affordable
42 Care Act in 2014 and the impending challenges caused by the retirement of the “baby
43 boom” generation), the RFS needs to continue to look ahead for modes by which
44 residents and fellows can become involved in their AMA. Providing proportional
45 representation to specialties and then creating At-Large positions were positive steps
46 forward in helping to improve RFS participation and to increase attendance at the
47 meetings. However, there still remains minimal resident and fellow participation in
48 certain states, as fully detailed in Appendix C. Granting representation to GME
49 institutions could significantly increase participation in the RFS Assembly and further

1 eliminate barriers that keep RFS members from becoming involved in organized
2 medicine.

3

4 **V. Recommendations**

5

1. That a system for establishing the number of, the selection process for, and the caucusing and seating arrangements of GME Delegates be outlined by the AMA-RFS Governing Council through collaboration with the CLRP as part of a "pilot project".
2. That a report be presented to the Assembly at I-12 but no later than A-13.

Fiscal note: None

AMERICAN MEDICAL ASSOCIATION RESIDENT AND FELLOW SECTION

Report: G
(A-11)

Introduced by: RFS Governing Council
Subject: Making At-Large Delegate Positions Permanent
Referred to: Reference Committee

1 **I. Introduction**

2
3 At the 2010 Annual Meeting of the American Medical Association Resident and Fellow
4 Section (AMA-RFS), the Assembly adopted Report H, "Enhancing Involvement of New
5 AMA-RFS Meeting Attendees". This report asked:

- 6
7 1. That the RFS-CLRP develop specific criteria for the use of At-Large positions;
8
9 2. That the RFS pilot the use of At-Large positions at I-10.
10
11 3. That the RFS-CLRP report the results of the pilot at A-11 and the Assembly vote
12 to determine if the pilot becomes permanent.

13
14 **II. Background**

15
16 Several barriers to serving in the AMA-RFS Assembly have been identified for both first
17 time attendees and more seasoned members over the past three years. When
18 Assembly participation declined from an average of 140 participants prior to 2006 to as
19 few as 76 in 2008, Governing Council members and AMA staff began to look more
20 critically at potential barriers and new opportunities for involvement. In light of declining
21 participation, questions were raised if the RFS Assembly was still representative of its
22 peers and if the associated financial expenditures were justifiable.

23
24 ***Barriers for Research Symposium participants***

25
26 In regards to opportunities to increase Assembly participation, the dramatically growing
27 Research Symposium was identified as a viable source. Most of the Symposium
28 participants were first time attendees who received funding from their residency or
29 fellowship programs to attend the Symposium. Some of the Symposium participants,
30 when contacted, were interested in participating in the Assembly and others were not.
31 After a successful Research Symposium in November, 2007, we had several
32 Symposium participants that wanted to fully participate in the Assembly meeting, instead
33 of just being observers. A Governing Council member tried to help them get
34 credentialed by filling Delegate seats that were left empty by States. Although not all
35 were able to credential because some states had filled all their Delegate seats, most
36 were able to fully participate as voting members.

1
2 The credentialing rules were adjusted in 2008 to allow unfilled, state seats to be filled by
3 Symposium participants. The primary criteria was that the individual had to be a
4 member of their state association. For some Symposium participants, this was their first
5 exposure to organized medicine and they had just become members of the AMA to
6 participate in the Symposium. Consequently, they were not members of their state
7 association and could not be credentialed.

8
9 In 2009, specialty societies were given proportional representation in the RFS Assembly.
10 This had been required by the RFS Internal Operating Procedure (IOP), since its
11 creation and adoption in 2006, but was extremely challenging to implement. The
12 increase in specialty representation, along with a growing Research Symposium,
13 boosted RFS participation from an average of 76 in 2008 to an average of 137 in 2009.
14 Between the unfilled state and specialty seats, almost all Symposium participants were
15 able to participate in the RFS Assembly, if desired, with the exception of those who were
16 not members of the societies they wanted to represent.

17
18 Barriers surfaced, however, when these Symposium participants wanted to remain
19 involved in the RFS by attending subsequent meetings and, therefore, require the
20 endorsement of their state or specialty society. Although we encourage states and
21 specialties to fill all their allotted seats, many do not due to economic restraints or other
22 reasons. In addition, it appears that some states and specialties do not even
23 offer/promote these opportunities to their resident and fellow members (i.e. Arkansas,
24 Delaware, Georgia, Hawaii, Idaho, Iowa, Kansas, Kentucky, Maine, Montana, Nevada,
25 New Hampshire, North Carolina, North Dakota, Oklahoma, Rhode Island, Vermont,
26 Wyoming and several specialties). Consequently, new members who want to remain
27 engaged in the RFS Assembly, after gaining some exposure due to the Symposium,
28 often face barriers to obtaining a delegate or alternate position in the AMA-RFS
29 Assembly. Consequently, some new members become discouraged and their
30 involvement in, and future contributions to, the AMA are lost. The creation of At-Large
31 Delegate positions would eliminate these barriers.

32 33 ***Barriers for new and existing Assembly members***

34
35 The At-Large Delegate position would also enable AMA-RFS Assembly members who
36 move to a different state, due to transferring residency programs, starting fellowship or
37 other circumstances, to remain active in the RFS Assembly. Historically, some
38 residents/fellows who have relocated to another state have faced barriers to climbing up
39 the leadership structure quickly enough to obtain endorsement and remain active in the
40 RFS Assembly. Or, they have moved to states that do not have an RFS Section and/or
41 the state does not offer the delegate positions that they have been allocated in the RFS
42 Assembly. According to the "Fifty State Resident and Fellow Initiative" report at A-10, at
43 least eleven states do not have an RFS Section for their members. The creation of At-
44 Large Delegate positions give these residents an opportunity to remain involved in the
45 AMA-RFS.

46 47 **III. Discussion**

48
49 The At-Large Delegate pilot program was implemented at I-10. The positions were
50 primarily promoted to the Research Symposium participants; however, promotion would

1 be much broader if the Assembly voted to make these positions permanent. For
2 example, these positions could be promoted at residency orientations, grand round
3 programs, and through publications that are sent to program directors. For the I-10
4 meeting, the RFS had three At-Large applicants. One of those At-Large Delegates ran
5 for, and was elected to, an Alternate Sectional Delegate position at the meeting. He has
6 since obtained an endorsement from his state to serve as an RFS Sectional Delegate in
7 the HOD.

8
9 Although there were only three people who applied for At-Large Delegate positions,
10 many should have been placed into these positions during credentialing. In fact, there
11 were 27 people that were credentialed onsite that neither received endorsement from
12 their state or specialty nor registered for the meeting. Therefore, these 27 individuals,
13 which include some long-standing participants, should have been considered At-Large
14 members but they were allowed to credential as representatives of their state or
15 specialty.

16
17 The RFS-Assembly also had a large number of people who registered for the I-10
18 meeting as “non-voting participants” or “other.” Of the 156 people that registered for the
19 meeting, 21 registered as “non-voting participants” and 27 registered as “other.” The
20 “other” category consisted primarily of Research Symposium participants who were
21 encouraged to register but participated very little, if at all, in the Assembly. The non-
22 voting participants likely sat in the back and observed the Assembly at various times and
23 may be a good source of new Delegates. These non-voting participants were likely
24 Research Symposium participants, fourth-year medical students and local residents.
25 We sent invitations to many of the residents in the San Diego area, which had some
26 effects on the registration numbers.

27
28 For the pilot at I-10, the number of At-Large Delegate positions offered was 10% of the
29 total number of registered delegates at A-10. There were 150 registered delegates at A-
30 10, so 15 At-Large Delegate positions were created. The reason for using the number of
31 A-10 registrants instead of I-10 registrants is because these positions are offered before
32 people have the opportunity to register for the upcoming meeting. However, we are
33 recommending that the number of At-Large positions be based on the average of the
34 prior year’s registered Delegates. Both state and specialty representation is also based
35 on the prior year’s membership numbers.

36 37 **IV. Summary**

38
39 One of the goals of the AMA-RFS is to increase membership and the active participation
40 of our members. To accomplish this, we must continue to cultivate interest among our
41 members and eliminate identified barriers for both active and new members. Several
42 options have been explored throughout the past three years. After exploring and
43 implementing many alternatives, as described in Report H, “Enhancing Involvement of
44 New AMA-RFS Meeting Attendees,” permanently creating At-Large Delegate positions
45 appears to be the most impactful and far reaching option to eliminate identified barriers
46 for those who want to participate in the RFS Assembly. As a result of being innovative
47 and forward-thinking, the Assembly has again started to flourish as illustrated by the
48 following:

- 49
50 • The average participation at Annual and Interim 2008 was 76 people.

- 1 • The average participation at Annual and Interim 2009 was 120 people.
- 2 • The average participation at Annual and Interim 2010 was 150 people.

3
4 **V. Recommendations**

- 5
6 1. The AMA-RFS Governing Council recommends that the AMA-RFS Internal
7 Operating Procedure (IOP) be amended by insertion and deletion and that the
8 remainder of the report be filed.

9
10 **IX. RFS Assembly Meeting**

11
12 There shall be an Assembly meeting of resident and fellow members of the AMA-RFS held
13 on a day prior to each meeting of the AMA House of Delegates.....

14
15 **B. Representatives to the Business Meeting.**

16
17 4. At-Large Delegate Members. Resident/fellow physicians serving in approved training
18 programs or fellowships, members serving as their primary occupation in a structured
19 educational program begun immediately upon completion of medical school, residency or
20 fellowship training who are direct or federation members of the AMA may be selected by the
21 AMA-RFS Governing Council as representatives to the Business Meeting of the Resident
22 and Fellow Section. At-Large Delegate representation shall be 10% of the average number
23 of registered delegates of the prior year.

24
25 Criteria for the At-Large Delegate positions include the following:

- 26
27 A. All seats are self-funded;
28 B. A candidate must be an AMA member;
29 C. A candidate must submit an application to the RFS Governing
30 Council for consideration;
31 D. A candidate will be able to select whether to serve in this position for
32 one meeting (Interim or Annual) or for an academic year;
33 E. There are no term limits for these positions but candidates must
34 reapply after each year;
35 F. All vacant positions after Interim will be offered for Annual;
36 G. Reasons for applying should include one of the following:
37 i. First time attendee; or
38 ii. Relocation due to a transition period; or
39 iii. State or Specialty does not send representatives to the RFS
40 Assembly or does not have an RFS Section; or
41 iv. Candidate is a direct AMA member

42
43 4 5. National Medical Specialty Organizations....

44
45 5 6. Professional Interest Medical Associations....

46
47 6 7. National Resident and Fellow Organizations...

48
49 7 8. Official Observer....

Fiscal note: None

Report F Supplemental Material
Appendix C

**2011 AMA-RFS Interim Meeting Delegation Breakdown
State Society Representation**

Society	RFS Delegates Allotted	RFS Delegates Credentialed	Symposium Participants Credentialed	Society	RFS Delegates Allotted	RFS Delegates Credentialed	Symposium Participants Credentialed
AL	3	2		NV	1	0	
AK	1	0		NH	1	0	
AZ	3	0		NJ	7	0	
AR	5	0		NM	2	0	
CA	25	7		NY	23	15	3
CO	4	1		NC	8	2	
CT	4	1		ND	1	1	
DE	2	0		OH	16	2	
DC	3	0		OK	7	1	
FL	12	4	1	OR	1	0	
GA	5	0		PA	14	3	
HI	2	0		RI	2	0	
ID	1	0		SC	4	4	
IL	13	6		SD	1	0	
IN	11	4		TN	5	2	
IA	3	0		TX	21	2	
KS	2	0		UT	3	0	
KY	4	0		VT	1	0	
LA	6	4		VA	8	3	
ME	2	0		WA	4	1	
MD	7	7		WV	2	1	
MA	13	13		WI	10	5	
MI	25	8	2	WY	1	0	
MN	13	6	2	AIR FORCE	1	1	
MS	2	1		ARMY	1	1	
MO	6	1		NAVY	1	0	
MT	1	0					
NE	2	2	1	Total	323	111	9

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**2011 AMA-RFS Interim Meeting Delegation Breakdown
Specialty Society Representation**

Society	Allotted	Creden- tialed	Symp. Partici- pants	Society	Allotted	Creden- tialed	Symp. Partici- pants
Amer. Acad. of Child and Adolescent Psychiatry	1	0		Amer. Coll. of Radiology	1	1	
Amer. Acad. of Dermatology	2	1		Amer. Coll. of Surgeons	4	0	
Amer. Acad. of Facial Plastic + Reconstructive Surgery	1	1		Amer. Psychiatric Assn.	5	0	
Amer. Acad. of Family Physicians	15	0		Amer. Soc. for Dermatologic Surgeons	1	1	1
Amer. Acad. of Hospice and Palliative Medicine	1	1		Amer. Soc. for Reproductive Medicine	1	0	
Amer. Acad. of Neurology	2	1		Amer. Soc. of Addiction Medicine	1	0	
Amer. Acad. of Otolaryngology – Head and Neck Surgery	3	0		Amer. Soc. of Anesthesiologists	9	1	
Amer. Society of Interventional Pain Physicians	1	0		Amer. Soc. of Clinical Pathologists	1	1	
Amer. Acad. of Pediatrics	4	1		Amer. Soc. of Internal Medicine	8	0	
Soc. for Vascular Surgery	1	0		Amer. Soc. of Plastic Surgeons	1	1	
Amer. Assn. of Neurological Surgeons	1	1		Amer. Society of Therapeutic Radiology	1	0	
Amer. Coll. of Allergy, Asthma, and Immunology	1	1		Amer. Urological Assn.	1	1	
Soc. of Nuclear Medicine	1	0		Assn. of Preventative Medicine	1	0	
Amer. Coll. of Emergency Physicians	3	3		Coll. of Amer. Pathologists	3	3	2
Amer. Coll. of Obstetricians and Gynecologists	8	4		Amer. Acad. of Physical Medicine and Rehabilitation	1	1	
Amer. Coll. of Occupational and Environmental Medicine	1	0		Amer. Acad. of Ophthalmology	1	0	
Amer. Coll. of Physicians	8	1	1	Soc. for Investigative Dermatology	1	0	
Amer. Coll. of Preventative Medicine	1	0		Soc. of Critical Care Medicine	1	1	
Amer. Coll. of Radiation Oncology	1	1	1				
				Total	98	27	5

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**2011 AMA-RFS Interim Meeting Delegation Breakdown
At-Large Representation**

State	RFS At-Large Delegates Who Reside in State	RFS At-Large Delegates Who Reside in State and Attended I-11 as Symposium Participants
CA	1	
FL	1	
LA	1	1
MA	1	
MS	1	
NE	2	2
NY	3	2
OH	1	1
PA	2	
VA	2	1
Total	15	7