

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(A-08)

Introduced by: Resident and Fellow Section, Massachusetts Medical Society, California
Medical Association, Medical Society of the State of New York

Subject: Removing Financial Barriers to Care for Transgender Patients

Referred to: Reference Committee A

1 Whereas, The American Medical Association opposes discrimination on the basis of
2 gender identity¹ and
3
4 Whereas, Gender Identity Disorder (GID) is a serious medical condition recognized as
5 such in both the Diagnostic and Statistical Manual of Mental Disorders (4th Ed., Text
6 Revision) (DSM-IV-TR) and the International Classification of Diseases (10th Revision),²
7 and is characterized in the DSM-IV-TR as a persistent discomfort with one's assigned
8 sex and with one's primary and secondary sex characteristics, which causes intense
9 emotional pain and suffering;³ and
10
11 Whereas, GID, if left untreated, can result in clinically significant psychological distress,
12 dysfunction, debilitating depression and, for some people without access to appropriate
13 medical care and treatment, suicidality and death;⁴ and
14
15 Whereas, The World Professional Association For Transgender Health, Inc. ("WPATH")
16 is the leading international, interdisciplinary professional organization devoted to the
17 understanding and treatment of gender identity disorders,⁵ and has established
18 internationally accepted Standards of Care⁶ for providing medical treatment for people
19 with GID, including mental health care, hormone therapy and sex reassignment surgery,
20 which are designed to promote the health and welfare of persons with GID and are
21 recognized within the medical community to be the standard of care for treating people
22 with GID; and
23
24 Whereas, An established body of medical research demonstrates the effectiveness and
25 medical necessity of mental health care, hormone therapy and sex reassignment
26 surgery as forms of therapeutic treatment for many people diagnosed with GID;⁷ and
27
28 Whereas, Health experts in GID, including WPATH, have rejected the myth that such
29 treatments are "cosmetic" or "experimental" and have recognized that these treatments
30 can provide safe and effective treatment for a serious health condition;⁷ and
31
32 Whereas, Physicians treating persons with GID must be able to provide the correct
33 treatment necessary for a patient in order to achieve genuine and lasting comfort with
34 his or her gender, based on the person's individual needs and medical history;⁸ and
35
36 Whereas, The AMA opposes limitations placed on patient care by third-party payers
37 when such care is based upon sound scientific evidence and sound medical opinion;^{9, 10}
38 and

1 Whereas, Many health insurance plans categorically exclude coverage of mental health,
 2 medical, and surgical treatments for GID, even though many of these same treatments,
 3 such as psychotherapy, hormone therapy, breast augmentation and removal,
 4 hysterectomy, oophorectomy, orchiectomy, and salpingectomy, are often covered for
 5 other medical conditions; and

6
 7 Whereas, The denial of these otherwise covered benefits for patients suffering from GID
 8 represents discrimination based solely on a patient's gender identity; and

9
 10 Whereas, Delaying treatment for GID can cause and/or aggravate additional serious and
 11 expensive health problems, such as stress-related physical illnesses, depression, and
 12 substance abuse problems, which further endanger patients' health and strain the health
 13 care system; therefore be it

14
 15 RESOLVED, That the AMA support public and private health insurance coverage for
 16 treatment of gender identity disorder (Directive to Take Action); and be it further

17
 18 RESOLVED, That the AMA oppose categorical exclusions of coverage for treatment of
 19 gender identity disorder when prescribed by a physician (Directive to Take Action).

Fiscal Note: No significant fiscal impact.

References

1. AMA Policy H-65.983, H-65.992, and H-180.980
2. Diagnostic and Statistical Manual of Mental Disorders (4th ed.. Text revision) (2000) ("DSM-IV-TR"), 576-82, American Psychiatric Association; International Classification of Diseases (10th Revision) ("ICD-10"), F64, World Health Organization. The ICD further defines transsexualism as "[a] desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex." ICD-10, F64.0.
3. DSM-IV-TR, 575-79
4. Id. at 578-79.
5. World Professional Association for Transgender Health: <http://www.wpath.org>. Formerly known as The Harry Benjamin International Gender Dysphoria Association.
6. The Harry Benjamin International Gender Dysphoria Association's Standards of Care for Gender Identity Disorders, Sixth Version (February, 2001). Available at <http://wpath.org/Documents2/socv6.pdf>.
7. Brown G R: A review of clinical approaches to gender dysphoria. J Clin Psychiatry. 51(2):57-64, 1990. Newfield E, Hart S, Dibble S, Kohler L. Female-to-male transgender quality of life. Qual Life Res. 15(9):1447-57, 2006. Best L, and Stein K. (1998) "Surgical gender reassignment for male to female transsexual people." Wessex Institute DEC report 88; Blanchard R, et al. "Gender dysphoria, gender reorientation, and the clinical management of transsexualism." J Consulting and Clinical Psychology. 53(3):295-304. 1985; Cole C, et al. "Treatment of gender

- dysphoria (transsexualism).” Texas Medicine. 90(5):68-72. 1994; Gordon E. “Transsexual healing: Medicaid funding of sex reassignment surgery.” Archives of Sexual Behavior. 20(1):61-74. 1991; Hunt D, and Hampton J. “Follow-up of 17 biologic male transsexuals after sex-reassignment surgery.” Am J Psychiatry. 137(4):432-428. 1980; Kockett G, and Fahrner E. “Transsexuals who have not undergone surgery: A follow-up study.” Arch of Sexual Behav. 16(6):511-522. 1987; Pfafflin F and Junge A. “Sex Reassignment. Thirty Years of International Follow-Up Studies after Sex Reassignment Surgery: A Comprehensive Review, 1961-1991.” IJT Electronic Books, available at <http://www.symposium.com/ijt/pfaefflin/1000.htm>; Selvaggi G, et al. "Gender Identity Disorder: General Overview and Surgical Treatment for Vaginoplasty in Male-to-Female Transsexuals." Plast Reconstr Surg. 2005 Nov;116(6):135e-145e; Smith Y, et al. “Sex reassignment: outcomes and predictors of treatment for adolescent and adult transsexuals.” Psychol Med. 2005 Jan; 35(1):89-99; Tangpricha V, et al. “Endocrinologic treatment of gender identity disorders.” Endocr Pract. 9(1):12-21. 2003; Tsoi W. “Follow-up study of transsexuals after sex reassignment surgery.” Singapore Med J. 34:515-517. 1993; van Kesteren P, et al. "Mortality and morbidity in transsexual subjects treated with cross-sex hormones." Clin Endocrinol (Oxf). 1997 Sep;47(3):337-42; World Professionals Association for Transgender Health Standards of Care for the Treatment of Gender Identity Disorders v.6 (2001).
8. The Harry Benjamin International Gender Dysphoria Association’s Standards of Care for Gender Identity Disorders, at 18.
 9. Id.
 10. AMA Policy H-120.988

Relevant AMA policy

H-65.983 Nondiscrimination Policy

The AMA opposes the use of the practice of medicine to suppress political dissent wherever it may occur. (Res. 127, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CEJA Rep. 2, A-05)

H-65.992 Continued Support of Human Rights and Freedom

Our AMA continues (1) to support the dignity of the individual, human rights and the sanctity of human life, and (2) to oppose any discrimination based on an individual's sex, sexual orientation, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies. (Sub. Res. 107, A-85; Modified by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmation A-05)

H-180.980 Sexual Orientation as Health Insurance Criteria

The AMA opposes the denial of health insurance on the basis of sexual orientation. (Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97)

H-120.988 Patient Access to Treatments Prescribed by Their Physicians

The AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an unlabeled indication when such use is based upon

sound scientific evidence and sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as reasonable and necessary medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate "off-label" uses of drugs on their formulary. (Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-08)

Introduced by: Resident and Fellow Section
Subject: Physician Scientist Benefit Equity
Referred to: Reference Committee C

1 Whereas, The importance of physician-scientists to modern medicine is well known as “Virtually
2 everything now used in clinical medicine can trace its roots to investigations performed in a
3 clinical or basic science department...;”¹ and
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5 Whereas, The number of physician-scientists has been steadily declining and “There are nearly
6 25% fewer physician-scientists on medical school faculties today than two decades ago;”² and
7
8 Whereas, The reasons for the decline in the number of physician-scientists are numerous, they
9 are known to include “the heavy accumulation of debt through many years of research
10 training...” and “questions about earning a living from academic life:”² and
11
12 Whereas, A significant loss of benefits can occur when house staff work as physician-scientists
13 and receive salary support from research training grants, such as provided by the National
14 Institutes of Health (NIH) and other programs, including loss of health insurance, medical liability
15 insurance, life insurance, disability insurance, and retirement benefits; and
16
17 Whereas, This loss of benefits can present a disincentive to resident physicians pursuing a
18 research career and furthering medical knowledge to improve patient care; and
19
20 Whereas, This loss of benefits produces inequities between resident physicians serving in
21 research versus clinical roles within the same institution; therefore be it
22
23 RESOLVED, That our AMA support the concept that all resident and fellow physicians who
24 function in a role as physician scientists are provided with benefits packages comparable to
25 those provided to their peers in clinical residencies or fellowships, to include disability insurance,
26 life insurance, HIV indemnity, malpractice insurance including tail coverage, retirement benefits,
27 health, sick leave and wages commensurate with their education and experience, and if a given
28 benefit or salary is provided to some residents within a given program at the same postgraduate
29 level, then that benefit must be provided to all residents.

Fiscal Note: No significant fiscal impact

References

1. Neilson EG, Ausiello D, and Demer LL. J. Invest. Med. 1995, 43(6), 534-542
2. Neilson EG. [J. Clin. Invest.](#) 2003, 111(6),765-7.

Relevant AMA-RFS Policy

310.799R Benefit Packages for Resident Physicians

Resolved 1) that the AMA-RFS seek to assure that all institutions be required to provide their resident physicians with disability insurance, life insurance, HIV indemnity, malpractice insurance including tail coverage, retirement benefits, health, sick leave and wages commensurate with their education and experience; and 2) if a given benefit or salary is provided to some residents within a given program at the same postgraduate level, then that benefit must be provided to all residents. However, this provision cannot be used to eliminate the benefit in question. (RFS Substitute Resolution 13, I-92; Reaffirmed: RFS Report C, I-02)

310.992R Minimum Resident Benefits

Asked that the AMA-RFS continue to monitor the revision of the "General Requirements" of the Essentials of Accredited Residencies in Graduate Medical Education for significant changes in benefits language, and act on them as appropriate within current AMA-RFS actions and AMA policies. (RFS Report I, I-89; Reaffirmed, RFS Report C, I-99)

Relevant AMA Policy

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)

H-310.999 Guidelines for Housestaff Contracts or Agreements

The "Essentials of Approved Residencies, " approved by the House of Delegates in 1970, includes a section on relationships of housestaff and institutions. The following outline is intended to promote additional guidance to all parties in establishing the conditions under which house officers learn and provide services to patients.

Training programs have been central to the process of graduate medical education which has produced a high level of medical competence in the United States. The American Medical

Association recognizes that the integrity of these programs is a primary objective in achieving the best possible care of the patient. It is, therefore, incumbent upon members of the housestaff and the institutions in which they are being trained to be aware of the parameters and responsibilities applicable to their training programs. In the absence of such awareness, unreasonable expectations may arise to threaten the harmony between hospital and housestaff in the performance of their joint mission.

It should be emphasized that these guidelines are not intended as a fixed formula. Guidelines that seek to cover public, voluntary and proprietary hospitals necessarily entail so many variables from training institution to training institution that no single form of contract or agreement would be universally applicable. This set of guidelines has, therefore, been developed to cover the more significant substantive provisions of a housestaff contract or agreement.

The subjects included in the Guidelines are not intended to be the only subjects important or appropriate for a contract or agreement. Moreover, the definition of the respective responsibilities, rights and obligations of the parties involved can assume various forms: individual contracts or agreements, group contracts or agreements, or as a part of the rules of government of the institution.

II. Proposed Terms and Conditions A. *Parties to the Contract or Agreement* (1) Contracts or agreements may be formed between individuals or groups, and institutions. Such a group might be a housestaff organization. (2) The two parties to an agreement or contract may be a single institution or a group of institutions, and an individual member of the housestaff, an informal group of the housestaff, or a formally constituted group or association of the housestaff, as determined by the housestaff organization.

B. *General Principles* (1) Contracts or agreements are legal documents and must conform to the laws, rules, and regulation to which the institutions are subject. Position, salary and all other benefits should remain in effect insofar as possible without regard to rotational assignments even when the member of the housestaff is away from the parent institution. Exceptions required by law or regulations should be clearly delineated to the house officer at the time of the appointment. Changes in the number of positions in each year of a training program should be made so as not to affect adversely persons already in, or accepted in, that program. The agreement should provide fair and equitable conditions of employment for all those performing the duties of interns, residents and fellows. When a general contract or agreement is in effect between an association and an institution, individual contracts or agreements should be consistent. (2) Adequate prior notification of either party's intent not to review the contract or agreement should be required, and the date of such notification should be included in the contract or agreement. (3) The institution and the individual members of the housestaff must accept and recognize the right of the housestaff to determine the means by which the housestaff may organize its affairs, and both parties should abide by that determination; provided that the inherent right of a member of the housestaff to contract and negotiate freely with the institution, individually or collectively, for terms and conditions of employment and training should not be denied or infringed. No contract should require or prescribe that members of the housestaff shall or shall not be members of an association or union.

C. *Obligation of the Housestaff* (1) Members of the housestaff agree to fulfill the educational requirements of the graduate training programs, and accept the obligation to use their efforts to provide safe, effective and compassionate patient care as assigned or required under the circumstances as delineated in the ACGME "Essentials of Approved Residencies" and previously approved standards of the AMA Council on Medical Education. (2) Members of the housestaff should comply with the laws, regulations, and policies to which the institution is subject.

D. *Obligation of the Institution* (1) The institution agrees to provide an educational program that meets the standards of the ACGME "Essentials of Approved Residencies." (2) The institution agrees to maintain continuously its staff and its facilities in compliance with all of the standards in the ACGME "Essentials of Approved Residencies."

E. *Salary for Housestaff* (1) The salary to be paid and the frequency of payment should be specified. The salary schedule should be published. The basis for increments and the time of the increments should be specified. (2) In determining the salary level of a member of the housestaff, prior educational experience should be considered, and a determination made as to whether credit should be given. (3) The responsibilities of senior residents should be recognized in salary differentials.

F. *Hours of Work* There should be recognition of the fact that long duty hours extending over an unreasonably long period of time or onerous on-call schedules are not consistent with the primary objective of education or the efficient delivery of optimal patient care. The institution should commit itself to fair scheduling of duty time for all members of the housestaff, including the provision of adequate off-duty hours.

G. *Off-Duty Activities* The contract or agreement should provide that a member of the housestaff is free to use his off-duty hours as he sees fit, including engaging in outside employment if permitted by the terms of the original contract or agreement, so long as such activity does not interfere with his obligations to the institution or to the effectiveness of the educational program to which he has been appointed.

H. *Vacation and Leave* The AMA encourages residency programs across the country to permit and schedule off-duty time separate from personal vacation time to enable residents to attend educational and/or organized medicine conferences. The amount of vacation, sick leave, and educational leave to which each member of the housestaff is entitled should be specified. Vacations should be expressed in terms of customary working days as defined by the institution. If vacations may be taken only at certain times of the year, this restriction should be stated. Any requirements for scheduling vacation time should also be stated. Provisions may also cover leaves for maternity, paternity, bereavement, military duty, examinations and preparations therefore, and educational conferences. Reimbursement for tuition and expenses incurred at educational conferences should be considered. The agreement should set forth any progressive increases in the amount of time allowed for vacation, sick leave, and educational leave. Educational leave should not be deducted from vacation time.

I. *Insurance Benefits* Insurance benefits should be set forth with particularity and should be tailored to the specific needs of the housestaff. Some of the more common insurance benefit provisions are (1) hospitalization and basic medical coverage for the member of the housestaff, spouse, and minor children; (2) major medical coverage for the member of the housestaff, spouse, and minor children; and (3) group life insurance, and dismemberment and disability insurance for the member of the housestaff only. It should also be specified whether the institution will pay the full amount of premiums or only a portion of the premiums, the balance to be paid by the member of the housestaff. Co-paid benefits should be established, separately from other hospital employee benefits, as a means of maximizing benefits. In some instances, free care for the housestaff and their families at the training institutions may be provided. In lieu of insurance benefits, the contract or agreement may provide for fixed annual payments to a housestaff association for each member of the housestaff so that the housestaff association may determine and provide for insurance or other benefits for the housestaff.

J. *Professional Liability Insurance* The contract or agreement should specify the amount of professional liability insurance that the institution will provide for each member of the housestaff together with the limits of liability applicable to such coverage. It might also be appropriate to provide in the contract or agreement that the housestaff and the institution will cooperate fully with the insurance company in the handling of any professional liability claim.

K. *Committee Participation* Insofar as possible, the institution should agree to provide for appropriate participation by the housestaff on the various committees within the institution. This participation should be on committees concerning institutional, professional and administrative matters including grievance and disciplinary proceedings. Members should have full voting rights. Representatives of the housestaff should be selected by the members of the housestaff.

L. *Grievance Procedures* The contract or agreement should require and publish a grievance procedure. A grievance procedure typically involves the following: (1) A definition of the term "grievance" (e.g., any dispute or controversy about the interpretation or application of the contract, any rule or regulation, or any policy or practice). (2) The timing, sequence, and end point of the grievance procedure. (3) The right to legal or other representation. (4) The right of an individual member of the housestaff or a housestaff association to initiate a grievance procedure and the obligation of the housestaff to maintain patient care during the grievance procedure. (5) A statement of the bases and procedures for the final decision on grievances (end point), and agreement of both parties to abide by the decision. (6) Should costs arise in the grievance procedure, a prior agreement as to how these costs will be apportioned between the parties.

M. *Disciplinary Hearings and Procedure* With respect to disciplinary procedures, the provisions of Article VIII - Hearing and Appellate Review Procedure of the JCAHO Guidelines for the Formulation of Medical Staff Bylaws, Rules, and Regulations shall be applicable to the housestaff in the same manner as they are to all other members of the medical staff with the proviso that the Hearing and Appeals Committees shall contain appropriate representation of the housestaff.

N. *Description of the Educational Program* The specific details of the operation of the educational experience should be made available to each prospective candidate. These data should include specific descriptions of training programs, including numbers of resident positions at each level of training, copies of existing housestaff contracts or agreements, approval status of programs to which candidate is applying, methods of evaluation, procedures for grievances and disciplinary action, and commitments for further training.

O. *Patient-Care Issues* The quality of patient-care services and facilities may be specified in the contract, and could include such matters as adequate equipment, bedspace, clinical staffing, and clinical staff structuring.

P. *Other Provisions* The agreement should provide for adequate, comfortable, safe, and sanitary facilities.

The foregoing provisions are not all-inclusive. Depending upon the institution's size, resources, location, and affiliations, if any, and also depending upon the relationship between the institution and the housestaff association, other provisions may be included, such as: (1) Maintenance of existing benefits and practices not otherwise expressly covered; (2) Housing, meals, laundry, uniforms, living-out and telephone allowances; (3) Adequate office space, facilities, and supporting services for housestaff affairs; (4) Housestaff association seminars and meetings. (BOT Rep. H, I-74; Reaffirmed: CLRPD Rep. C, A-89; Appended: Res.323, I-97; Reaffirmation A-00)

H-310.929 Principles for Graduate Medical Education

Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies of Graduate Medical Education, if they are not already present.

(1) **PURPOSE OF GRADUATE MEDICAL EDUCATION.** There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.

Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be

modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(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.

(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution. (CME Rep. 9, A-99)

H-295.942 Providing Dental and Vision Insurance to Medical Students and Resident Physicians

The AMA urges (1) all medical schools to pay for or offer affordable policy options and, assuming the rates are appropriate, require enrollment in disability insurance plans by all medical students; (2) all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans; (3) medical schools and residency training programs to pay for or offer comprehensive and affordable health insurance coverage, including but not limited to medical, dental, and vision care, to medical students and residents which provides no less than the minimum benefits currently recommended by the AMA for employer-provided health insurance and to require enrollment in such insurance; (4) carriers offering disability insurance to: (a) offer a range of disability policies for medical students and residents that provide sufficient monthly disability benefits to defray any educational loan repayments, other living expenses, and an amount sufficient to continue payment for health insurance providing the minimum benefits recommended by the AMA for employer-provided health insurance; and (b) include in all such policies a rollover provision allowing continuation of student disability coverage into the residency period without medical underwriting. (5) Our AMA: (a) actively encourages medical schools, residency programs, and fellowship programs to provide access to portable group health and disability insurance, including human immunodeficiency virus positive indemnity insurance, for all medical students and resident and fellow physicians; (b) will work with the ACGME and the LCME, and other interested state medical societies or specialty organizations, to develop strategies and policies to ensure access to the provision of portable health and disability insurance coverage, including human immunodeficiency virus positive indemnity insurance, for all medical students, resident and fellow physicians; and (c) will prepare informational material designed to inform medical students and residents concerning the need for both disability and health insurance and describing the available coverage and characteristics of such insurance. (BOT Rep. W, I-91; Reaffirmed: BOT Rep. 1, I-934; Appended: Res. 311, I-98; Modified: Res. 306, A-04)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-08)

Introduced by: Resident and Fellow Section

Subject: Evaluation of Increasing Resident Review Committee (RRC) Requirements

Referred to: Reference Committee C

1 Whereas, The creation of the Outcome Project and the development of the six core
2 competencies from the Accreditation Council for Graduate Medical Education has lead to a
3 novel and valuable shift in the focus of graduate medical education toward competency-based
4 learning; and
5
6 Whereas, The shift in focus to competency-based learning has created a need for new
7 assessment tools, structured curricula, and extensive documentation of resident performance
8 data in an attempt to quantify a largely qualitative experience; and
9
10 Whereas, Excessive documentation requirements could detract from time available for
11 residents and fellows to learn directly from patients during clinical encounters and less time for
12 staff to teach residents, therefore be it
13
14 RESOLVED, That the AMA study residency/fellowship documentation requirements for
15 program accreditation and the impact of these documentation requirements on program
16 directors and residents with recommendations for improvement.

Fiscal Note: Estimated cost of \$38,602 to visit between 10 to 20 GME sponsoring institutions and analyze work effort involved by a representative sample of program directors and Designated Institutional Officers to respond to ACGME accreditation requirements.

Relevant AMA Policy

H-315.982 CMS Documentation Guidelines for Teaching Physicians

The AMA will work with the CMS to: (1) reduce the redundant and burdensome documentation for teaching physicians; (2) accept documentation by the physician team under the supervision of a teaching physician if it collectively meets all CMS documentation requirements; and (3) accept a statement of the teaching physician's level of participation in patient care as sufficient or adequate documentation. (Res. 861, A-98)

D-300.995 Reducing Burdens of CME Accreditation and Documentation

Our AMA will work with the Accreditation Council for Continuing Medical Education to simplify the requirements for documentation and administration of accredited CME programs. (Res. 304, I-01)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-08)

Introduced by: Resident and Fellow Section

Subject: Loss of Status Following Family Medical Leave Act (FMLA) Qualified Leave
During Residency Training

Referred to: Reference Committee C

- 1 Whereas, Current AMA policy (H-420.967) states “Physicians should be able to return to their
2 practices or training programs after taking maternity leave without the loss of status”; and
3
- 4 Whereas, The Family Medical Leave Act (FMLA) guarantees that eligible employees be given “a
5 minimum of twelve weeks of unpaid leave per year” for certain medical and family reasons
6 (including pregnancy/childbirth) and be restored “to the same or an equivalent position” upon
7 their return to work¹; and
8
- 9 Whereas, Certain residency training programs require residents taking family medical leave
10 (including maternity leave) for periods protected under the FMLA (up to 12 weeks) to repeat the
11 entire year, citing this requirement as necessary to maintain board eligibility²; and
12
- 13 Whereas, Specialty board policies regarding board eligibility do not seem to explicitly require a
14 resident taking family medical leave to repeat the entire year (rather than simply extend training)
15 in the event of a resident taking a period of leave protected under the FMLA^{3,4}; and
16
- 17 Whereas, Residents who must repeat an entire year of training as a direct result of taking an
18 FMLA-protected maternity leave suffer a “loss of status”, as well as lost potential income, as a
19 result of taking maternity leave; and
20
- 21 Whereas, Perpetuation of policies that result in this kind of “loss of status” due to residents
22 taking maternity leave lowers morale for many residents and may discourage women from
23 entering the specialty of their choice^{5,6}; and
24
- 25 Whereas, Residency programs imposing such a requirement as a result of actual or falsely
26 construed specialty board policy may unknowingly be committing a tort against those residents
27 who suffered a “loss of status” and those who did not take desired leave as a result of the threat
28 of “loss of status”; and
29
- 30 Whereas, The policies of the specialty boards regarding family medical leave and board
31 eligibility requirements are extremely variable between specialties and confusing to residents
32 and faculty alike; therefore be it
33
- 34 RESOLVED, That our AMA oppose requiring residents to repeat a year of training when
35 returning to work following a leave that qualifies under the federal Family Medical Leave Act
36 (New HOD Policy); and be it further
37

- 1 RESOLVED, That our AMA urge the American Board of Medical Specialties and its member
 2 boards to be in compliance with the Family Medical Leave Act and to retract any policies that do
 3 not comply (Directive to Take Action).

Fiscal Note: Less than \$1000

References

1. U.S. Department of Labor: Compliance Assistance - Family and Medical Leave Act. <http://www.dol.gov/esa/whd/fmla/>
2. Jagsi R, Tarbell, NJ, and DF Weinstein. Supplement to "Becoming a Doctor, Starting a Family — Leaves of Absence from Graduate Medical Education." *New England Journal of Medicine*, 2007; 357(19): 1889-1891.
3. American Board of Orthopedic Surgery, Inc. 2008 Rules and Procedures for Residency Education. <https://www.abos.org/documents/2008RP.doc>
4. Rose, SH, Burkle CM, Elliott BA, et al. "The Impact of Parental Leave on Extending Training and Entering the Board Certification Examination Process." *Mayo Clinic Proceedings*. 2006; 81(11):1449-53.
5. Jagsi R, Tarbell, NJ, and DF Weinstein. "Becoming a Doctor, Starting a Family — Leaves of Absence from Graduate Medical Education." *New England Journal of Medicine*, 2007; 357(19): 1889-1891.

Relevant AMA Policy:

H-420.967 Maternity Leave Policies

Over the past decade, the medical community has made significant progress in responding to the unique needs of women medical students and physicians, including the issue of maternity leave. The continuation and enhancement of these efforts should be encouraged. Therefore, (1) The AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of written maternity leave policies as part of the physician's standard benefit agreement.

(2) AMA policy regarding recommended components of maternity leave policies for physicians, as specified in Policy 420.987 is expanded to include physicians in practice, reading as follows:

(a) Residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' work loads, particularly in residency programs; and (c) Physicians should be able to return to their practices or training programs after taking maternity leave without the loss of status.

(3) Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their maternity leave policies a six-week minimum leave allowance, with the understanding that no woman should be required to take a minimum leave. (BOT Rep. HH, I-90; Modified: Sunset Report, I-00)

H-420.961 Education -- Policies for Maternity, Family and Medical Necessity Leave for Residents and Employed Physicians

AMA adopts as policy the following guidelines for, and encourage the implementation of, Maternity and Family Leave for Residency Programs and Employed Medical Staffs: (1) The AMA urges medical schools, residency training programs, medical specialty boards, and the

Accreditation Council for Graduate Medical Education to incorporate and/or encourage development of written leave policies, including parental leave, family leave, and medical leave; (2) Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave; (3) Physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons; (4) Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling; (5) Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs; (6) Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status; and (7) Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up); because of leave for eligibility for board certification. Residency program directors must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility. (CME Rep. 6, A-98; Reaffirmation I-03)

H-420.979 AMA Statement on Family and Medical Leave

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98)

H-420.987 Maternity Leave for Residents

The AMA believes that: (1) Residency program directors should review federal law concerning maternity leave and note that for policies to be in compliance, pregnant residents must be allowed the same sick leave or disability benefits as other residents who are ill or disabled. (2) The duration of disability leave should be determined by the pregnant resident's physicians, based on the individual's condition and needs. (3) All residency programs should develop a written policy on maternity and paternity leave for residents that addresses: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; (i) leave policy for adoption; and (j) leave policy for paternity. (4) Resident numbers and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other residents' work loads. (5) Residents should be able to return to their training program after disability leave without loss of training status. (BOT Rep. Z, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CME Rep. 2, A-04)

H-420.996 Maternity Leave for Housestaff

Our AMA encourages flexibility in residency training programs, incorporating maternity leave and alternative schedules for pregnant housestaff. (Sub. Res. 89, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

D-310.970 Improving Parental Leave Policies for Residents

Our AMA will study and encourage the Accreditation Council for Graduate Medical Education's participation in such study of (1) the feasibility of considering guaranteed paid maternity leave for residents of no less than six weeks duration, with the possibility of unpaid maternity leave of an additional six weeks; (2) written leave policies for residents for paternity and adoption; and (3) the effect of such maternity, paternity, and adoption leave policies on residency programs, with report back to the House of Delegates at the 2008 Annual Meeting. (Res. 303, A-07)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 317
(A-08)

Introduced by: Resident and Fellow Section

Subject: Telemedicine and Medical Licensure

Referred to: Reference Committee C

- 1 Whereas, The advancement of telemedicine will allow patients both in the United States of
2 America and worldwide to obtain excellence in healthcare; and
3
- 4 Whereas, Telemedicine promotes increased access to healthcare by eliminating travel
5 expenses, aiding those with impediments to mobility, and connecting patients directly with the
6 most highly trained physicians in the world; and
7
- 8 Whereas, Physicians who wish to obtain a U.S. state medical license must first successfully
9 pass all three Steps of the United States Medical Licensing Examination, an examination
10 sponsored by the National Board of Medical Examiners, not a state board medical examination;
11 and
12
- 13 Whereas, Physicians wishing to be board certified in the U.S. must successfully pass their
14 respective specialty board examination(s), usually a national board examination for each
15 specialty, not a state specific specialty board exam; and
16
- 17 Whereas, Physicians nationwide should, to the best of their ability, practice medicine according
18 to evidence-based medicine, regardless of where the physician was trained, the state in which
19 the physician treats patients, or the state in which the patient is a permanent resident; and
20
- 21 Whereas, Currently each state has its own medical license which must be successfully applied
22 for and maintained if a physician wishes to treat patients in that state (with limited consultative
23 exceptions), and the application for and acquisition of a state medical license is typically a long
24 process; and
25
- 26 Whereas, For physicians engaging in repetitive telemedicine activities, the maintenance of
27 multiple active medical licenses is economically prohibitive as annual or semi-annual renewal
28 fees accrue; and
29
- 30 Whereas, Physicians with a valid state license who practice in a Veterans Health Administration
31 (VHA) Hospital are permitted to work in VHA hospitals beyond the state in which they are
32 licensed, without being required to hold multiple licenses; and
33
- 34 Whereas, Our patients should be free to seek healthcare they deem most appropriate and the
35 AMA should lead the charge for constant medical innovation by supporting increased access to
36 excellent medical care; therefore be it
37
- 38 RESOLVED, That the AMA study how guidelines regulating medical licenses are affected by
39 telemedicine and medical technological innovations that allow for physicians to practice outside
40 their states of licensure (Directive to Take Action).

Fiscal Note: Estimated cost of \$135,128 to develop instrument and conduct survey and follow up.

Relevant AMA Policy:

H-160.937 The Promotion of Quality Telemedicine

(1) The AMA adopts the following principles for the supervision of nonphysician providers and technicians when telemedicine is used: (a) The physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine. (b) Physician supervision (e.g. regarding protocols, conferencing, and medical record review) is required when nonphysician providers or technicians deliver services via telemedicine in all settings and circumstances. (c) Physicians should visit the sites where patients receive services from nonphysician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the nonphysician providers utilized. (d) The supervising physician should have the capability to immediately contact nonphysician providers or technicians delivering, as well as patients receiving, services via telemedicine in any setting. (e) Nonphysician providers who deliver services via telemedicine should do so according to the applicable nonphysician practice acts in the state where the patient receives such services. (f) The extent of supervision provided by the physician should conform to the applicable medical practice act in the state where the patient receives services. (g) Mechanisms for the regular reporting, recording, and supervision of patient care delivered through telemedicine must be arranged and maintained between the supervising physician, nonphysician providers, and technicians. (h) The physician is responsible for providing and updating patient care protocols for all levels of telemedicine involving nonphysician providers or technicians.

(2) The AMA urges those who design or utilize telemedicine systems to make prudent and reasonable use of those technologies necessary to apply current or future confidentiality and privacy principles and requirements to telemedicine interactions.

(3) The AMA emphasizes to physicians their responsibility to ensure that their legal and ethical requirements with respect to patient confidentiality and data integrity are not compromised by the use of any particular telemedicine modality. (4) The AMA advocates that continuing medical education conducted using telemedicine adhere to the standards of the AMA's Physician Recognition Award and the Essentials and Standards of the Accreditation Council for Continuing Medical Education. (CME/CMS Rep., I-96; Reaffirmed: CMS Rep. 8, A-06)

H-480.974 The Evolving Impact of Telemedicine

Our AMA: (1) will evaluate relevant federal legislation related to telemedicine;

(2) urges CMS and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;

(3) urges medical specialty societies involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine; (Reaffirmed by CME/CMS Rep. A-96)

(4) encourages the CPT Editorial Board to develop CPT codes or modifiers for telemedical services;

(5) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;

(6) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine; and

(7) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. (CMS/CME Rep., A-94; Reaffirmation A-01)

H-480.969 The Promotion of Quality Telemedicine

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles: (a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state; (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation; (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices. (2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions. (3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99)

H-480.961 Teleconsultations and Medicare Reimbursement

Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07)

H-480.968 Telemedicine

AMA: (1) encourages all national specialty societies to work with their state societies to develop comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine; (2) will assist the national specialty societies in their efforts to develop these guidelines and standards; and urges national private accreditation organizations (e.g., URAC and JCAHO) to require that medical care organizations which establish ongoing arrangements for medical care delivery from remote sites require practitioners at those sites to

meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery. (Res. 117, I-96; Reaffirmed: CSAPH Rep. 3, A-06)

H-480.984 Technology Assessment in Medicine

(1) The AMA believes that technology assessment programs and coverage determinations should be based upon the following principles in order to assure sound clinical practice and equitable public policy: (a) The primary objective of health care technology assessment should be the development of accurate and complete information for physicians on safety, effectiveness, and clinical indications in order to enhance the appropriate utilization of health care technology. (b) The development of information on safety, effectiveness, and indications for use should be based upon a rigorous scientific methodology. (c) The primary responsibility for the conduct of technology assessment should rest with the medical profession, with participation from both the research and practice communities. Participation in such assessment by all appropriate medical specialties is important, particularly when use of the technology crosses specialties. (d) The pluralistic approach to technology assessment in both the public and private sectors should be strongly encouraged and continued. (e) The results of technology assessment must be communicated in an accurate and timely manner throughout the research and practice communities; specialty societies and other health care professional organizations should intensify efforts to disseminate such information. (f) Health care technologies should be re-evaluated on a continuing basis after their introduction, particularly if they are expensive or have the potential to cause serious harm if applied inappropriately. (g) Obsolete technologies should be identified and their further use should be discouraged. (h) Cost-effectiveness is an important consideration in technology assessment, but it should remain subordinate to considerations of safety and effectiveness. (i) Decisions as to the cost-effectiveness of technology can best be made by the physician on an individual patient basis, taking into consideration the needs of the individual and the results of cost-effectiveness analyses. Therefore, cost-effectiveness should not be used by payers to preclude or limit the availability of a safe and effective technology by either refusal to reimburse or by the provision of more limited reimbursement for such technology. (j) Payer determinations regarding coverage for health care technologies must be made with the involvement of the medical community and the public. Such determinations should be timely and responsive to the evolving information on safety and effectiveness. (k) Payer coverage policies for investigational technologies should be flexible and reviewed frequently so as to assure that the needs of individual patients are met. (l) Payers should integrate the concept of risk/benefit analysis into their decision-making and adapt their coverage policy accordingly. In serious and life-threatening illnesses, payers must recognize that patient and physician may agree upon a particular therapy, notwithstanding a lesser degree of certitude about that therapy's safety and effectiveness, if no other alternative therapies are available.

(2) The AMA should continue its efforts to educate the public about the contributions of innovations in health care technology to the health and well-being of all people and the prevention of disease.

(3) The AMA should emphasize access to effective technologies (and reimbursement for such technologies) which may be more appropriate for a subset of patients, even though other technologies may be more effective for the majority of patients for a given clinical condition, in order to protect physician judgment and patient preference in selection of therapy.

(4) When safety, effectiveness and availability have been established, cost should be a substantial determining factor in the choice of technology. (Joint CMS/CSA Rep., I-90; Reaffirmed: In Lieu of Res. 711, I-93; Amended: CSA Rep. 8, A-03)

H-275.955 Physician Licensure Legislation

Our AMA (1) reaffirms its policies opposing discrimination against physicians on the basis of being a graduate of a foreign medical school and supports state and territory responsibility for admitting physicians to practice; and (2) reaffirms earlier policy urging licensing jurisdictions to adopt laws and rules facilitating the movement of physicians between states, to move toward uniformity in requirements for the endorsement of licenses to practice medicine, and to base endorsement of medical licenses on an assessment of competence rather than on passing a written examination of cognitive knowledge. (CME Rep. B, A-90; Reaffirmation A-00)

H-275.962 Proposed Single Examination for Licensure

Our AMA: (1) endorses the concept of a single examination for medical licensure; (2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination, (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and (6) urges that appointing graduates of LCME accredited medical schools to accredited residency training not be dependent on their passing Steps I and II or the single examination for licensure. (CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-275.967 Licensure by Endorsement

The AMA opposes national legislation which would mandate licensing reciprocity by all state licensing authorities. (Res. 42, A-88; Reaffirmed: Sunset Report, I-98)

H-275.978 Medical Licensure

The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent; (2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure; (3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends; (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice; (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public; (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94); (7) urges licensing boards to maintain strict confidentiality of reported information; (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board; (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board

take appropriate and immediate steps to correct any adverse consequences to the physician; (10) urges all physicians to participate in continuing medical education as a professional obligation; (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine; (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient; (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review; (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation; (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public; (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses; (17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses; (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination; (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; and (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement. (CME Rep. A, A-87; Modified: Sunset Report, I-97; Reaffirmation A-04)

H-275.993 Examinations for Medical Licensure

Our AMA affirms its recommendation that medical school faculties continue to exercise the responsibilities inherent in their positions for the evaluation of students and residents, respectively. (CME Rep. B, I-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-08)

Introduced by: Resident and Fellow Section

Subject: Protecting Patients and Residents by Reducing Extended Work Shifts

Referred to: Reference Committee C

- 1 Whereas, Five years have passed since both the American Medical Association (AMA) and the
2 American Council on Graduate Medical Education (ACGME) adopted specific duty hour
3 restrictions to protect residents, fellows, and patients^{i,ii}; and
4
- 5 Whereas, The current duty hour restrictions continue to allow residents and fellows to work for
6 up to 30 continuous hours with no dedicated time for sleep; and
7
- 8 Whereas, A growing body of literature published mostly in the past five years has shown that
9 decreasing or eliminating extended work shifts (defined as shifts greater than 16 hours) may
10 improve both resident quality of life and patient safety^{iii,iv,v,vi,vii,viii,ix,x,xi,xii}; and
11
- 12 Whereas, This same body of literature also suggests that decreasing or eliminating extended
13 shifts does not compromise resident education, even for residents in surgical
14 programs^{xiii,xiv,xv,xvi,xvii,xviii,xix,xx,xxi,xxii,xxiii}; and
15
- 16 Whereas, Despite the accumulated evidence, it would be premature to create a new mandate
17 eliminating extended work shifts for residents and fellows at a time when many residency
18 programs are still struggling to comply with the current duty hour restrictions; and
19
- 20 Whereas, Residency programs can instead be encouraged to voluntarily reduce or eliminate
21 extended work shifts in order to improve resident quality of life and patient safety, allowing
22 individual programs to move towards this goal at their own pace; and
23
- 24 Whereas, Decreasing or eliminating extended work shifts will require new team-based
25 approaches to patient care as well as improvements in the way physicians communicate patient
26 information to each other at the time of shift-change; therefore be it
27
- 28 RESOLVED, That our AMA reaffirm support of the current ACGME duty hour restrictions, and
29 be it further
30
- 31 RESOLVED, That our AMA encourage the voluntary reduction or elimination of extended work
32 shifts (>16 hours) for residents and fellows by academic medical centers and teaching hospitals
33 while opposing a new ACGME mandate at this time, and be it further
34
- 35 RESOLVED, That our AMA continue to evaluate outcomes-based research on the impact of
36 reductions in extended work shifts on (1) Patient Safety, (2) Resident Education, (3) Resident
37 Safety, (4) Resident Quality of Life and (5) Professionalism in Transfer of Care, and be it further
38

- 1 RESOLVED, That our AMA develop specific prioritized research questions/objectives to further
 2 evaluate issues related to resident duty-hour reforms, such as best practices for signing out
 3 patients and organizing patient care teams.

ⁱⁱ H-310.927

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-08)

Introduced by: Resident and Fellow Section
Subject: Pediatric Suspected Intentional Trauma
Referred to: Reference Committee D

- 1 Whereas, More than 6,000,000 children were reported as maltreated and 899,000 were
2 confirmed victims by child protective services in 2005,¹ and
3
4 Whereas, 62.8 percent of victims experienced neglect, 16.6 percent were physically abused, 9.3
5 percent were sexually abused, 7.1 percent were psychologically maltreated, and 2.0 percent
6 were medically neglected,¹ and
7
8 Whereas, 1460 children died in 2005 from child abuse,¹ and
9
10 Whereas, Recent studies demonstrate that only 50-60% of abuse related deaths are reported
11 making child abuse deaths as the least reported form of fatal maltreatment,² and
12
13 Whereas, Children who experience maltreatment are at increased risk for adverse health effects
14 and behaviors as adults—including smoking, alcoholism, drug abuse, eating disorders, severe
15 obesity, depression, suicide, sexual promiscuity, and certain chronic diseases,^{3,4} and
16
17 Whereas, Maltreatment during infancy or early childhood can cause important regions of the
18 brain to form improperly, leading to physical, mental, and emotional problems such as sleep
19 disturbances, panic disorder, and attention-deficit/hyperactivity disorder,⁵ and
20
21 Whereas, 25% to 30% of infant victims of shaken baby syndrome die from their injuries, and
22 nonfatal consequences of shaken baby syndrome include varying degrees of visual impairment
23 (e.g., blindness), motor impairment (e.g. cerebral palsy) and cognitive impairments,⁶ and
24
25 Whereas, Victims of child maltreatment who were physically assaulted by caregivers are twice
26 as likely to commit physical assault as adults,⁷ and
27
28 Whereas, The direct costs (judicial, law enforcement, and health system responses to child
29 maltreatment) are estimated at \$24 billion each year. The indirect costs (long-term economic
30 consequences of child maltreatment) exceed an estimated \$69 billion annually,⁸ and
31
32 Whereas, More than 53% of physicians do not report child abuse when they state they have a
33 suspicion for abuse,⁹ and
34
35 Whereas, Researchers found that 31% of traumatic head injuries were not recognized by the
36 physicians who first evaluated these victims,¹⁰ and
37

- 1 Whereas, Physicians serve on the front lines of detecting and diagnosing child abuse and yet
2 less than 57% of physicians who are mandated reporters receive any training regarding child
3 abuse reporting; therefore be it,¹¹
4
5 RESOLVED, That our AMA support comprehensive reporting and investigation of all cases of
6 reasonably suspected child abuse and neglect using an inclusive and interdisciplinary method in
7 accordance with state and federal laws; and be it further
8
9 RESOLVED, That our AMA support the creation of a national standardized pediatric intentional
10 trauma curriculum for medical students and residents.

Fiscal Note: Staff cost estimated at less than \$500 to implement.

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Relevant AMA Policy

H-515.989 Evidence of Standards for Child Sexual Abuse

The AMA continues to support the standardization of evidence in child sexual abuse cases and urges that examination and treatment of child abuse victims be done by a physician. (Res. 78, I-87; Reaffirmed: Sunset Report, I-97)

H-60-990 Child Pornography

The AMA (1) supports reassembling an interdisciplinary panel of experts periodically to continue to address shared concerns and information relevant to the issue of child pornography; (2) encourages and promotes awareness of child pornography issues among physicians; (3) through physicians, encourages parents to use the educational textbook entitled, *Sex Talk for a Safe Child*; (4) promotes physician awareness of the need for follow-up psychiatric treatment for all victims of child pornography; (5) encourages research on child abuse (including risk factors, psychological and behavioral impact, and treatment efficacy) and dissemination of the findings; (6) wherever possible, encourages international cooperation among medical societies to be alert to and intervene in child pornography activities; and (7) cooperates with other national organizations and federal and local agencies in addressing the problem of child pornography. (BOT Rep. Z, A-88; Reaffirmed: Sunset Report, I-98)

H-60.961 HHS to Require the States to Repeal the Religious Exemption in the Child Abuse and Neglect Prevention Statutes

The AMA will petition the Secretary of HHS to remove the religious exemption in child abuse and neglect cases from the Code of Federal Regulations and to exercise administrative authority to urge state officials to repeal existing child abuse and neglect religious exemption provisions in state statutes, thereby restoring equal protection under the law for all children. (Sub. Res. 219, A-93; Reaffirmed by BOT Rep. 24, A-97)

H-75.991 Requirements or Incentives by Government for the Use of Long-Acting Contraceptives

(1) Involuntary use of long-acting contraceptives because of child abuse raises serious questions about a person's fundamental right to refuse medical treatment, to be free of cruel and unusual punishment, and to procreate. The state's compelling interest in protecting children from abuse may be served by less intrusive means than imposing contraception on parents who have committed child abuse. The needs of children may be better met by providing close supervision of the parents, appropriate treatment and social services, and foster placement care when necessary. There is not sufficient evidence to demonstrate that long-acting contraceptives are an effective social response to the problem of child abuse. Before long-acting contraceptives could be considered as a response to individual cases of child abuse, the issue would need to be addressed by society broadly. Society must be careful about taking shortcuts to save resources when constitutional rights are involved. (2) Serious questions are raised by plea bargains, or negotiations with child welfare authorities, that result in the use of long-acting contraceptives. Such agreements are made in inherently coercive environments that lack procedural safeguards. In addition, cultural and other biases may influence decisions by the state to seek the use of a long-acting contraceptive. (3) If welfare or other government benefits were based on the use of long-acting contraceptive agents, individuals would be required to assume a potentially serious health risk before receiving their benefits. Government benefits should not be made contingent on the acceptance of a health risk. (4) Individuals should not be denied access to effective contraception because of their indigence. Use of long-acting

contraceptives should be covered by Medicaid and other health insurance programs, both public and private. (5) Long-acting contraceptives may be medically contraindicated. Assessing the health risks of long-acting contraceptives is substantially outside the purview of courts and legislatures. (BOT Rep. EE, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04)

H-60.992 Missing and Exploited Children

To enhance physician involvement with issues related to missing and exploited children, the AMA supports the following statements and activities: (1) Child abductions and runaway behaviors are harmful and emotionally upsetting, divisive, and chaos-producing to victims and their families. Any disappearance of a child constitutes a family crisis with both victims and families at high risk for developing physical and emotional problems. Any child who is the object of a custody dispute is vulnerable to parental snatching, running away and/or being abused. (2) Medical interventions, including family therapy, should occur immediately after a child is reported missing; if the child returns home or is found dead, physicians and other health care professionals should continue to monitor the victim patient and/or the patient's family. (3) Children abducted by family members or strangers should be considered victims of child abuse and such occurrences should be designated as reportable instances of child abuse under state statutes. (4) Prevention efforts should focus on reducing family stress, combatting alcoholism and drug abuse, dealing with poor marital relationships including divorce mediation and counseling, and providing supportive services for families at risk. (5) All shelter services that are presently available to runaways and homeless youths should contain a high quality health care component. Comprehensive standards of health care should be developed for the national network of runaway centers. Physicians should be consultants to and work with governing boards of these agencies. (6) Children's medical records should be intelligible and include a complete medical history, distinguishing physical characteristics and detailed information, as outlined in the Child Identification Form developed by the AMA. The AMA encourages physicians to utilize this form in their practice settings. Pediatricians and family physicians should encourage parents to arrange for the speedy transfer of the child's previous medical records and physicians should respond promptly to such requests. The parent's refusal to comply with this request should warrant further questioning of the parents or a report of a possible missing child. (7) At prevention, diagnostic and treatment levels, physicians should attempt to identify troubled children and their families early and ensure that appropriate treatment takes place or that referrals are made to the other medical specialists or community resources. (8) The primary care physician, medical examiner and dentist are key members of the missing child identification team, and should be knowledgeable about the steps to be taken (completing the NCIC forms) immediately after a child is reported missing. (9) Physicians should actively promote the practice of obtaining clear and readable fingerprints and footprints as a technically useful way to document these unique physical characteristics of children. (10) State medical societies should consider establishing committees on child abuse and neglect, with the topic of missing and exploited children included in the charge of responsibilities. (11) The AMA supports continued research on abducted children (both parent and stranger abductions), runaways, homeless youth and their families, and how physicians can help them. (12) All levels of medical education should emphasize the diagnosis, comprehensive treatment and prevention of problems associated with families that suffer from stress and that may be related to problems of alcoholism, drug abuse, domestic violence and marital dysfunction. Educational programs should address the reactions of physicians to these complex and frustrating social problems. (13) The AMA supports cooperating with the American Academy of Pediatrics, the American Psychiatric Association, the American College of Obstetricians and Gynecologists, and the College of American Pathologists in developing and disseminating information about the health care needs of missing children and effective prevention strategies. (14) The AMA supports cooperating with the American Bar Association, the American Psychiatric Association, law enforcement agencies and the National Center for Missing and Exploited Children in

considering the problem of identifying and tracking perpetrators of child abductions. (BOT Rep. O, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed and Modified: CSAPH Rep. 3, A-06)

H-245.984 Treatment Decisions for Seriously Ill Newborns

Physicians should play an active role in advocating for changes in the Child Abuse Prevention Act as well as state laws that require physicians to violate the ethical guidelines stated in E-2.215 (Treatment Decisions for Seriously Ill Newborns). (CEJA Rep. I, A-92; Modified and Reaffirmed: CEJA Rep. 1, A-03)

H-515.988 Repeal of Religious Exemptions in Child Abuse and medical Practice statutes

Our AMA (1) reaffirms existing policy supporting repeal of the religious exemption from state child abuse statutes; (2) recognizes that constitutional barriers may exist with regard to elimination of the religious exemption from state medical practice acts; and (3) encourages state medical associations that are aware of problems with respect to spiritual healing practitioners in their areas to investigate such situations and pursue all solutions, including legislation where appropriate, to address such matters. (BOT Rep. H, A-90; Reaffirmed: Sunset Report, I-00)

H-515.983 Physicians and Family Violence

Ethical Considerations: (1) The medical profession must demonstrate a greater commitment to ending family violence and helping its victims. Physicians must play an active role in advocating increased services for victims and abusers. Protective services for abused children and elders need to be better funded and staffed, and follow-up services should be expanded. Shelters and safe homes for battered women and their children must be expanded and better funded. Mechanisms to coordinate the range of services, such as legal aid, employment services, welfare assistance, day care, and counseling, should be established in every community. Mandatory arrest of abusers and greater enforcement of protection orders are important law enforcement reforms that should be expanded to more communities. There should be more research into the effectiveness of rehabilitation and prevention programs for abusers. (2) Informed consent for interventions should be obtained from competent victims of abuse. For minors who are not deemed mature enough to give informed consent, consent for emergency interventions need not be obtained from their parents. Physicians can obtain authorization for further interventions from a court order or a court-appointed guardian. (3) Physicians should inform parents of a child-abuse diagnosis and they should inform an elderly patient's representative when the patient clearly does not possess the capacity to make health care decisions. The safety of the child or elderly person must be ensured prior to disclosing the diagnosis when the parents or caretakers are potentially responsible for the abuse. For competent adult victims physicians must not disclose an abuse diagnosis to caregivers, spouses, or any other third party without the consent of the patient. (CEJA Rep. B, I-91; Reaffirmed: CSA Rep. 7, I-00; Modified and Reaffirmed: CEJA Rep. 1, A-03)

H-525.980 Expansion of AMA Policy on Female Genital Mutilation

The AMA (1) condemns the practice of female genital mutilation (FGM); (2) considers FGM a form of child abuse; (3) supports legislation to eliminate the performance of female genital mutilation in the United States and to protect young girls and women at risk of undergoing the procedure; and (4) supports that physicians who are requested to perform female genital mutilation on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with changing societal mores. (CSA Rep. 5, I-94; Res. 513, A-96; Reaffirmed: CSAPH Rep. 3, A-06)

D-60.982 Long Term Effects of Early Abuse/Neglect on Brain Development

Our AMA will: (1) work with national organizations, e.g., American Academy of Pediatrics, American Academy of Child and Adolescent Psychiatry, American College of Obstetricians and Gynecologists, and others involved with early brain research, child abuse and neglect and public education to make educational materials available to hospital infant and pediatric personnel, physicians, parents, other child care providers and educators and the public at large; (2) urge state and local medical societies to work with their legislators to put in place educational, and where appropriate, support programs for those involved with infants and young children, i.e., parents, students in junior and senior high school, child care providers, and early childhood educators; and (3) work with the federal government and pertinent agencies to make this issue--prevention of early abuse and brain damage with its devastating long term effects for individuals and society--a priority of our nation. (BOT Action in response to referred for decision Res. 526, A-02)

D-515-993 Support for Legislative Action and Improved Research on the Health Response to Violence and Abuse

Our AMA, in conjunction with other members of the Federation and the National Advisory Council on Violence and Abuse will: (1) identify and actively support state and federal legislative proposals designed to increase scientific knowledge, promote public and professional awareness, enhance recognition and ensure access to appropriate medical services for patients who have experienced violence and/or abuse; (2) actively support legislation and congressional authorizations designed to increase the nation's health care infrastructure addressing violence and abuse including proposals like the Health CARES (Child Abuse Research, Education and Services) Network; (3) actively support expanded funding for research on the primary prevention of violence and abuse, the cost of violence and abuse to the health care system, and the efficacy of interventions and methods utilized in the identification and treatment of victims of violence and abuse; (4) actively study the best practices in diagnosis and management of family violence (including an analysis of studies not reviewed in the recent US Preventive Services Task Force Recommendations on Screening for Family Violence) and present a report that identifies future research and practice recommendations; and (5) invite a Federation-wide task force to review and promote the best practices in the identification, management and prevention of family violence. (Res. 438, A-04)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 612
(A-08)

Introduced by: Resident and Fellow Section
Subject: Accuracy of Internet Physician Profiles
Referred to: Reference Committee A

- 1 Whereas, Various internet sites such as WebMD, VIMO and HealthGrades provide physician
2 provider information such as education/training, practice type, location, board certification
3 status, and disciplinary actions ¹; and
4
5 Whereas, Information provided in internet physician profiles is often obtained from third party
6 sources and may contain erroneous information such as inaccurate listing of specialty or
7 practice location, and these sites do not claim accuracy of the provided information ^{2,3,4}; and
8
9 Whereas, Physicians are not always notified that their provider information is being posted or
10 provided open access to their full information profile, and may even be required to pay to see
11 their full profile, and there is no mechanism for oversight of the physician profile information; and
12
13 Whereas, Patients are increasingly using the internet to review the credentials of their
14 physicians ⁵, and may receive misinformation from these internet sites, therefore be it
15
16 RESOLVED, That the AMA investigate the publication of physician information on internet
17 websites; and be it further
18
19 RESOLVED, That the AMA investigate potential solutions to erroneous physician information
20 contained on Internet websites with report back at I-08.

Fiscal Note: Implement accordingly at estimated staff cost of \$4,752.

References

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2. WebMD Legal disclaimer: "WebMD, its licensors, and its suppliers make no representations or warranties about the following: The accuracy, reliability, completeness, currentness, or timeliness of the Content, software, text, graphics, links, or communications provided on or through the use of the WebMD Site or WebMD" Accessed March 2, 2008 from <http://www.webmd.com/policies/about-terms-and-conditions-of-use#part4>.
3. VIMO legal disclaimer: "Vimo gathers data from a variety of different sources, public and private. While we strive to provide the most accurate, up-to-date information possible, we can't guarantee that our listings are completely without error" accessed March 2, 2008 from <http://www.vimo.com/html/copyright.php>.
4. HealthGrades legal disclaimer "HealthGrades obtains its information from sources it believes to be reliable. However, because of the possibility of human and mechanical error as well as other factors, HealthGrades makes no representations or warranties, express or implied, as to the accuracy or

timeliness of its information, and cannot be responsible or liable for any errors or omissions in its information or the results obtained from the use of such information." Accessed March 2, 2008 from http://www.healthgrades.com/consumer/index.cfm?fuseaction=modnw&modtype=content&modact=legal_disclaimer&tv_eng=home&tv=home.

5. Kaiser Family Foundation *Online Health Information Poised to Become Important Resource For Seniors, But Not There Yet* (January 12, 2005). Accessed March 2, 2008 from <http://www.kff.org/entmedia/entmedia011205nr.cfm>.

Relevant AMA Policy

H-406.996 Use and Release of Physician-Specific Health Care Data

(1) Our AMA advocates that third party payers, government entities and others that use and release physician-specific health care data adhere to the following principles: (a) Physicians under review and relevant physician organizations shall be provided with an adequate opportunity to review and respond to proposed physician-specific health care data interpretations and disclosures prior to their publication or release. (b) Effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate or subjective physician-specific health care data shall be established. (c) Reliable administrative, technical, and physical safeguards to prevent the unauthorized use or disclosure of physician-specific health care data shall be developed. (d) Such safeguards shall treat all underlying physician-specific health care data and all analyses, proceedings, records, and minutes from quality review activities on physician-specific health care data as confidential, and provide that none of these documents shall be subject to discovery, or admitted into evidence in any judicial or administrative proceeding. (2) Our AMA supports release of severity-adjusted physician-specific health care data from carefully selected pilot projects where the data may be deemed accurate, reliable, and meaningful to physicians, consumers, and purchaser; (3) Our AMA urges that any published physician-specific health care data be limited to appropriate data concerning the quality of health care, access to health care, and the cost of health care; (4) Our AMA opposes the publication of physician-specific health care data collected outside of carefully selected pilot studies or where the data are not deemed accurate, reliable, or meaningful; (5) Our AMA urges that a copy of the information in any such profile be forwarded to the subject physician, and that the physician be given the right to review and certify adequacy of the information prior to any profile being distributed, including being placed on the Internet; and (6) Our AMA urges that the costs associated with creation of any such profiling system should not be paid for by physicians licensure fees. (BOT Rep. Q, I-92; BOT Rep. W, A-92; Reaffirmed: Res. 719, A-93; CMS Rep. 10, A-96; Appended: Res. 316, I-97; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 724, A-05)

E-5.027 Use of Health-Related Online Sites

As Internet prevalence and access rapidly increases, individuals turn to the Internet to find health-related information quickly and efficiently. Online users can access innumerable informational or interactive online sites, many of which are maintained by physicians or rely on their services. Physician involvement should be guided by the following considerations: (1) Physicians responsible for the health-related content of an online site should ensure that the information is accurate, timely, reliable, and scientifically sound, and includes appropriate scientific references. (2) The provision of diagnostic or therapeutic services through interactive online sites, including advice to online users with whom the physician does not have a pre-existing relationship or the use of decision-support programs that generate personalized information directly transmitted to users, should be consistent with general and specialty-specific standards. General standards include truthfulness, protection of privacy, principles of informed consent, and disclosures such as limitations inherent in the technology. (3) When participating in interactive online sites that offer email communication, physicians should follow

guidelines established in Opinion 5.026, "The Use of Electronic Mail." (4) Physicians who establish or are involved in health-related online sites must minimize conflicts of interest and commercial biases. This can be achieved through safeguards for disclosure and honesty in funding and advertising. It also requires that physicians not place commercial interests ahead of patient health; therefore, physicians must not use health-related online sites to promote unnecessary services, refer patients to entities in which they have ownership interests, or sell products outside of established ethical guidelines. (See Opinions 2.19, "Unnecessary Services;" 8.032, "Conflicts of Interest: Health Facility Ownership by a Physician;" 8.062, "Sale of Non-Health-Related Goods from Physicians' Offices;" and 8.063, "Sale of Health-Related Products from Physicians' Offices"). Promotional claims on online sites must conform to Opinion 5.02, "Advertising and Publicity." (5) Physicians who establish or are involved in health-related online sites that use patient-specific information must provide high-level security protections, as well as privacy and confidentiality safeguards. (I, II, IV, V, VI) Issued December 2003 based on the report "Use of Health-Related Online Sites," adopted June 2003, (AJOB 2003; 3(3)).

H-478.999 An International Code of Ethics for Internet Health Sites

Our AMA supports of a universal code of ethics for Internet health sites. (Res. 615, A-00)

H-375.969 Physician Access to Performance Profile Data

AMA policy is that every physician should be given a copy of his/her practice performance profile information at least annually by each organization retaining such physician information. (Res. 827, A-98)