



## Resident 2 Agenda and Resolutions

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National Conference of Family Medicine Residents and Medical Students  
July 28 - 30, 2016 – Kansas City, MO

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1. Resolution No. R2-501      Dementia Awareness, Taskforce, and Toolkit Creation
2. Resolution No. R2-502      Advocating for the Removal of Prescriber Restrictions for Hepatitis C Direct Acting Antivirals
3. Resolution No. R2-503      Fostering Training in Hepatitis C Primary Care
4. Resolution No. R2-504      Incorporating Health Policy Education Into Medical Schools and Residency Programs
5. Resolution No. R2-505      Support Contraceptive Implant Training Among Family Physicians
6. Resolution No. R2-506      Residency Closure Assistance Program
7. Resolution No. R2-507      Physician Suicide Prevention
8. Resolution No. R2-508      Supporting Common Sense Gun Legislation
9. Resolution No. R2-509      A Shot in the Dark: The Lack of Gun Violence Research is a Public Health Issue
10. Resolution No. R2-510      Improving Patient Education of Limited English Proficiency Patients
11. Resolution No. R2-511      Improving Mental Health Care in the Primary Care Setting
12. Resolution No. R2-512      Offering Guidance to the ABFM Regarding the Maintenance of Certification Family Practice (MC-FP)
13. Resolution No. R2-513      The American Academy of Family Physicians to Support Accreditation Council for Graduate Medical Education Accredited Residencies in obtaining Osteopathic Recognition
14. Resolution No. R2-514      Talking Explicitly About Impact Bias
15. Resolution No. R2-515      Educating AAFP Constituents on Anti-violence Movements in the Community

16. Resolution No. R2-516 Resolution in Support of Promoting Health in Trade Agreements
17. Resolution No. R2-517 Resident Rotation Exchange
18. Resolution No. R2-518 Support of Physician Transparency (& Sunshine)
19. Resolution No. R2-519 Ending Direct Consumer Advertising
20. Resolution No. R2-520 Against Public Funding of Crisis Pregnancy Centers
21. Resolution No. R2-521 Advocacy for a Federal Ban on Reparative Therapy
22. Resolution No. R2-522 Advocacy and Policy Education and Training in Family Medicine Residency Programs

1 **RESOLUTION NO. R2-501**

2 **Dementia Awareness, Taskforce, and Toolkit Creation**

3 Introduced by: Jason R. Woloski, MD, Hershey, PA

4  
5 WHEREAS, Alzheimer's disease is the sixth leading cause of death in the United States, and

6  
7 WHEREAS, over five million Americans are living with Alzheimer's (1 in 9 people age 65 and  
8 older), and

9  
10 WHEREAS, in 2015 more than 15 million caregivers provided an estimated 18.1 billion hours of  
11 unpaid care related to dementia, and

12  
13 WHEREAS, morality related to dementia is higher than breast and prostate cancer combined,  
14 and

15  
16 WHEREAS, in 2016 costs related to dementia are estimated to be \$236 billion, and

17  
18 WHEREAS, earlier dementia detection allows for additional time for future planning and  
19 increases the likelihood for clinical trial acceptance, and

20  
21 WHEREAS, it is estimated every 66 seconds someone in the United States develops dementia,  
22 and

23  
24 WHEREAS, the American Academy of Family Physicians has proven effectiveness of task  
25 forces in the past, such as through the Primary Care Valuation Task Force, now, therefore, be it

26  
27 RESOLVED, That the American Academy of Family Physicians develop a dementia task force,  
28 comprised of at least one student and one resident physician representative, to further efforts  
29 aimed at increased dementia research funding, awareness, diagnosis, and treatment, and be it  
30 further

31  
32 RESOLVED, That the American Academy of Family Physicians advocate for comprehensive  
33 dementia research and awareness initiatives, and be it further

34  
35 RESOLVED, That the American Academy of Family Physicians develop an online dementia  
36 toolkit to assist primary care providers with office based tools, advocacy efforts, and community  
37 engagement, and be it further

38  
39 RESOLVED, That this resolution be referred to the 2016 Congress of Delegates.

1 **Resolution NO. R2-502**

2 **Advocating for the Removal of Prescriber Restrictions for Hepatitis C Direct Acting**  
3 **Antivirals**

4 Introduced by: Britt Gayle, Monroeville, PA

5

6 WHEREAS, The most recent Centers for Disease Control and Prevention (CDC) surveillance  
7 data indicates that approximately 3.5 million people in the United States are estimated to have  
8 Hepatitis C, and

9

10 WHEREAS, the CDC has also concluded that Hepatitis C kills more people than any other  
11 infectious disease in the United States, and

12

13 WHEREAS, Direct Acting Antivirals (DAAs) are significantly more effective, less toxic and  
14 require progressively shorter treatment courses than interferon based regimens, and

15

16 WHEREAS, the current prices of DAAs represent a significant challenge to health insurance  
17 budgets, but still cost less per cure than interferon containing regimen and are starting to  
18 decrease in price due to market competition, and

19

20 WHEREAS, the cost of treatment is significantly exceeded by the costs of hepatic and  
21 extrahepatic complications and viral transmission, and

22

23 WHEREAS, according to an assessment published in the Annals of Internal Medicine in 2015,  
24 in all 14 states Medicaid requires the prescriber of DAAs to be a gastroenterologist,  
25 hepatologist, infectious disease or transplantation specialist, and

26

27 WHEREAS, in 15 states Medicaid requires that a specialist consultation precedes prescription  
28 of DAAS, and

29

30 WHEREAS, some commercial insurance plans have similar restrictions, and

31

32 WHEREAS, limiting DAA prescription prior authorizations to specialists increases health care  
33 costs to the patient, health insurance and health system and creates an additional barrier to  
34 health care access and medication adherence, and

35

36 WHEREAS, many family physicians across the country are successfully treating and caring for  
37 patients with Hepatitis C, using the Hepatitis C management guidelines that are freely available  
38 online, and

39

40 WHEREAS, data from the Hepatitis C ASCEND study demonstrates that primary care providers  
41 equipped with additional training can deliver equally effective care when compared to  
42 specialists, and

43

44 WHEREAS, the American Academy of Family Physicians in conjunction with other  
45 organizations has issued a request to the Centers for Medicare and Medicaid Services (CMS) to  
46 remove prescriber restrictions and specialist consultation requirements, and

47

48 WHEREAS, the CMS and Children's Health Insurance Program Services has already  
49 expressed concerns that state programs are restricting access to DAAs contrary to statutory  
50 requirements, now therefore, be it

51  
52 RESOLVED, That the American Academy of Family Physicians create a collection of advocacy  
53 resources to disseminate to chapters in states where prescriber restrictions exist in order to  
54 assist in raising awareness of the impact of Direct Acting Antiviral (DAA) prescriber restrictions  
55 and advocating for their removal, and be it further

56  
57 RESOLVED, That the American Academy of Family Physicians establishe a task force  
58 comprised of private, academic, rural and resident family physicians to augment advocacy  
59 efforts at a national level to remove Direct Acting Antiviral prescriber restrictions.

1 **RESOLUTION NO. R2-503**

2 **Fostering Training in Hepatitis C Primary Care**

3 Introduced by: Britt Gayle, M.D., Monroeville, PA

4  
5 WHEREAS, The most recent Centers for Disease Control and Prevention (CDC) surveillance  
6 data indicates that approximately 3.5 million people in the United States are estimated to have  
7 Hepatitis C, and

8  
9 WHEREAS, the CDC has also concluded that Hepatitis C kills more people than any other  
10 infectious disease in the United States, and

11  
12 WHEREAS, family physicians play a significant role in identifying those infected with Hepatitis  
13 C, and

14  
15 WHEREAS, numerous family medicine residency programs have started incorporating Hepatitis  
16 C care into their curricula and some have established fellowships, and

17  
18 WHEREAS, many family physicians across the country are successfully treating and caring for  
19 patients with Hepatitis C, and

20  
21 WHEREAS, the Hepatitis C management guidelines are freely available online, and

22  
23 WHEREAS, entities such as the American Association for the Study of Liver Diseases (AASLD)  
24 and the International Antiviral Society-USA (IAS-USA) have online and in-person educational  
25 opportunities focusing on Hepatitis C care, and

26  
27 WHEREAS, certification programs providing specialized training in HIV care and Tropical  
28 Medicine already exist and are held by many family physicians, and

29  
30 WHEREAS, recent evidence demonstrates that primary care providers equipped with additional  
31 training can deliver equally effective Hepatitis C care when compared to specialists, now,  
32 therefore, be it

33  
34 RESOLVED, That the American Academy of Family Physicians create a curriculum guideline on  
35 Hepatitis C detection and management, and be it further

36  
37 RESOLVED, That the American Academy of Family Physicians collaborate with entities that  
38 already have Hepatitis C primary care-oriented educational content to create a certification  
39 process focusing on Hepatitis C management.

1 **RESOLUTION NO. R2-504**

2 **Incorporating Health Policy Education Into Medical Schools and Residency Programs**

3 Introduced by: Laura Doan, MD, Los Angeles, CA  
4 Jeremy Mosher, Vallejo, CA  
5 Megan Chock, San Diego, CA  
6 Redmond Finney, Baltimore, MD  
7 Abeer Mousa, Tucson, AZ  
8

9 WHEREAS, Evidence shows that medical students have significant gaps in knowledge  
10 concerning the U.S. health-care system, and  
11

12 WHEREAS, evidence shows that most medical students perceive that these deficiencies are not  
13 adequately addressed in the medical school curriculum, and  
14

15 WHEREAS, 96 percent of surveyed medical students felt that knowledge of health policy is  
16 important to their career, and  
17

18 WHEREAS, there have been several recent calls for increased attention to health policy in  
19 medical education, both in the undergraduate and post-graduate education of physicians, and  
20

21 WHEREAS, the Accreditation Council for Graduate Medical Education (ACGME) endorses  
22 “systems-based practice,” which requires a broader knowledge of the health-care system, as  
23 one of the six general competencies expected of all residents, and  
24

25 WHEREAS, the Society of General Internal Medicine Task Force for Residency Reform  
26 recommended increased training to reduce health disparities, which should include curricular  
27 focus to address social and cultural issues of care, health policy, and health economics, and  
28

29 WHEREAS, there is a growing awareness that doctors need more training in the non-clinical  
30 parts of health care, and  
31

32 WHEREAS, there are several excellent and long-standing health policy courses educating  
33 residents on health policy topics applicable to daily physician practices, exposing residents to  
34 health policy careers through visits with policy makers and analysts, and promoting personal  
35 engagement in health policy, now, therefore, be it  
36

37 RESOLVED That the American Academy of Family Physicians (AAFP) explore a model two-to-  
38 four week or longitudinal health policy curriculum that can be modified by chapters based on  
39 local policies and that medical schools and residency training programs can use to teach  
40 students and residents, and be it further  
41

42 RESOLVED, That the American Academy of Family Physicians (AAFP) ask the Liaison  
43 Committee on Medical Education (LCME) and American Osteopathic Association (AOA)  
44 Commission on Osteopathic College Accreditation (COCA) to consider using the AAFP’s model  
45 curriculum as part of their accreditation guidelines for medical schools, and be it further  
46

47 RESOLVED, That the American Academy of Family Physicians (AAFP) ask the Accreditation  
48 Council for Graduate Medical Education (ACGME) to consider using the AAFP’s model  
49 curriculum as part of their accreditation guidelines for family medicine residency programs.

1 **RESOLUTION NO. R2-505**

2 **Support Contraceptive Implant Training Among Family Physicians**

3 Introduced by: Margot Brown, Santa Rosa, CA  
4 Matt Mullane, Denver, CO  
5

6 WHEREAS, The American Academy of Family Physicians (AAFP) supports that “long-acting  
7 reversible contraception be offered as a first-line contraceptive method for women with  
8 reproductive capacity,” and  
9

10 WHEREAS, the AAFP Curriculum Guidelines for Family Medicine Residents (2014) advocates  
11 for competency in Intrauterine Device (IUD) insertion and removal and subcutaneous implant  
12 insertion and removal, and  
13

14 WHEREAS, contraceptive implants are highly effective and safe for most women, including  
15 adolescents and nulliparous women, and  
16

17 WHEREAS, contraceptive implants may decrease rates of unintended pregnancy compared to  
18 shorter acting methods, such as the oral contraceptive pill, and  
19

20 WHEREAS, IUD use among women 15-44 who use contraception has increased from 1.5% in  
21 2002 to 6.4% in 2013, implant use has only increased from .3% to.8% in the same time period,  
22 and  
23

24 WHEREAS, one barrier to obtaining implants for appropriate and interested women is lack of  
25 family physician training regarding eligibility, insertion and removal of the devices, and  
26

27 WHEREAS, a 2016 study found that only 11.3% of practicing family physicians insert and/or  
28 remove the contraceptive implant, compared to 51.3% of obstetricians/gynecologists, and  
29

30 WHEREAS, a further barrier to implant access is a required in-person or web-based provider  
31 training sponsored by the manufacturer, and  
32

33 WHEREAS, family physicians who completed residency less than 21 years ago are more likely  
34 than those who completed residency longer than 21 years ago to insert or remove implants,  
35 suggesting the CME is needed to address this training gap, and  
36

37 WHEREAS, physicians who receive continuing education on implant insertion and removal have  
38 a five times greater odds of implant utilization within their practice, now, therefore, be it  
39

40 RESOLVED, That the American Academy of Family Physicians offer implant insertion and  
41 removal training for both residents and practicing family physicians, including consistent  
42 provision of hands-on training at state and national conference, and be it further  
43

44 RESOLVED, That the American Academy of Family Physicians petition the implant  
45 manufacturers to remove the mandatory industry-sponsored insertion and removal training  
46 session in favor of a peer-based training model.



1 **RESOLUTION NO. R2-506**

2 **Residency Closure Assistance Program**

3 Introduced by: Michael Richardson, MD, Boston, MA

4  
5 WHEREAS, Closures of family medicine residency programs are disruptive to resident learning  
6 and are emotionally challenging to navigate, and

7  
8 WHEREAS, Columbia University was able to overturn their residency closure in 2015 by  
9 garnering outside support to advocate for family medicine and its need in the community, and

10  
11 WHEREAS, the most current published researched on program closures was in 2003, noting  
12 that 27 residency programs submitted requests to withdraw accreditation between July 1, 2000,  
13 and July 1, 2002 , and

14  
15 WHEREAS, there is a lack of research on the impact of family medicine residency program  
16 closures and how to prevent them, and

17  
18 WHEREAS, the American Academy of Family Physicians (AAFP) Residency Program Solutions  
19 consultant group provides customized consultation services to address residency program  
20 needs at the request of residency directors and family medicine departments, and

21  
22 WHEREAS, there are currently AAFP resources for residents to navigate program closures,  
23 now, therefore, be it

24  
25 RESOLVED, That the American Academy of Family Physicians develop resources for residents  
26 and faculty to navigate program closures, such as an online reference guide and an active list of  
27 residency programs with open resident positions, and be it further

28  
29 RESOLVED, That the American Academy of Family Physicians examine the impact of program  
30 closures on residents and their affected communities, and be it further

31  
32 RESOLVED, That the American Academy of Family Physicians (AAFP) identify a representative  
33 in the AAFP's Residency Program Solutions consultant group to serve as a contact person for  
34 residents concerned about residency program closures.

1 **RESOLUTION NO. R2-507**

2 **Physician Suicide Prevention**

3 Introduced by: Joseph Brodine, Washington, DC  
4 Kristina Dakis, MD, Chicago, IL  
5 Mary Warren, Washington, DC  
6 Emily Graber, Chicago, IL  
7

8 WHEREAS, Physicians are two-three times more likely to commit suicide compared to the  
9 general U. S. population, and

10

11 WHEREAS, 10 percent of medical students and residents have experienced suicidal ideation in  
12 the last year, and

13

14 WHEREAS, physicians need to care for themselves in order to be fit to care of patient, now,  
15 therefore, be it

16

17 RESOLVED, That the American Academy of Family Physicians create an evidence-based  
18 online toolkit for medical students, residents, and practicing physicians for suicide prevention.

1 **RESOLUTION NO. R2-508**

2 **Supporting Common Sense Gun Legislation**

3 Introduced by: Stewart Decker, MD, Klamath Falls, OR  
4 Redmond Finney, Baltimore, MD  
5 Maya Siegel, Baltimore, MD  
6

7 WHEREAS, There were 33,636 gun deaths in the United States in 2013, which is a  
8 representative number over the last decade, and

9 WHEREAS, 62 percent of these deaths were completed suicides, 36 percent were homicides,  
10 and 2 percent were accidental deaths, and

11 WHEREAS, only 5.6 percent of all suicide attempts are with firearm, but 51-55 percent of  
12 completed suicides are with firearm, meaning that suicide attempts by firearm are 85 percent  
13 fatal, and

14 WHEREAS, firearms were used in 69.9 percent of all homicides in 2012, again a representative  
15 number, and

16 WHEREAS, if a person's preferred suicide method is unavailable, it is unlikely they will switch to  
17 a different one, and

18 WHEREAS, in the first week after the purchase of a handgun, the rate of suicide by means of  
19 firearms among purchasers was 57 times higher than the general population, and

20 WHEREAS, in the 11 states that have "waiting periods" there is a lower overall suicide rate  
21 ( $P=.001$ ), a lower firearms suicide rate ( $P<.001$ ), and a lower proportion of suicide deaths  
22 resulting from firearms, and

23 WHEREAS, in the year immediately following the repeal of their 48-hour waiting period law,  
24 South Dakota saw a 7.6-percent increase in its overall suicide rate compared with 3.3 percent  
25 for the United States in general, and

26 WHEREAS, in the year following implementation of a law that extended the waiting period for  
27 acquiring a handgun, Washington, DC, saw a 2.2-percent decrease in their overall suicide rate  
28 compared with a 2.1-percent increase in the United States overall, and

29 WHEREAS, states with laws that required background checks at the point of transfer or before  
30 obtaining a permit to purchase a handgun from a private seller exhibited a lower overall suicide  
31 rate ( $P<.001$ ), a lower firearms suicide rate ( $P<.001$ ), and a lower proportion of suicide deaths  
32 resulting from firearms (36.8 percent vs. 58.8 percent,  $P<.001$ ), and

33 WHEREAS, when threatening intimate partners, gun owners are 7.8 times more likely to  
34 threaten their partners with a gun than non-gun owners, and

35 WHEREAS, family and intimate partner assaults with firearms are 12 more times likely to result  
36 in death than non-firearm assaults, and

37 WHEREAS, the American Academy of Family Physicians (AAFP) currently "supports increased  
38 research," "supports strong and robust enforcement of existing federal, state, and local laws and  
39 regulations regarding the manufacture, sale and possession of funds," "supports legislation

40 restricting unsupervised access to both firearms and ammunition by children,” and “opposes  
41 private ownership of weapons designed primarily to fire multiple (greater than 10) rounds  
42 quickly,” and

43 WHEREAS, the AAFP has also stated that the “background-check requirement should be  
44 expanded to include the sale of firearms at gun shows, over the Internet and in classified ads,  
45 and has “call(ed) for ‘an elimination of the ban on federal funding for objective, scientific  
46 research on gun violence,’” and

47 WHEREAS, the AAFP has been uncharacteristically silent on gun control interventions such as  
48 waiting periods and laws about removing guns from homes with domestic violence claims, now,  
49 therefore, be it

50 RESOLVED, That the American Academy of Family Physicians (AAFP) support gun laws that  
51 demonstrably decrease morbidity and mortality associated with gun violence in any of its forms,  
52 including but not limited to a receipt of a gun-waiting period and allowance for removal of guns  
53 from houses during domestic violence complaints.

1 **Resolution NO. R2-509**

2 **A Shot in the Dark: The Lack of Gun Violence Research is a Public Health Issue**

3 Introduced by: Meray Ohanassian, Gainesville, FL  
4 Ashlin Mountjoy, MD, Seattle, WA  
5 Alexander Langley, MD, Seattle, WA  
6

7 WHEREAS, Gun violence accounts for 33,000 deaths and 76,000 non-fatal gun injuries each  
8 year in the United States, and  
9

10 WHEREAS, the United States has a homicide rate from gun violence that is 25.2 times greater  
11 than other high-income developed countries, and  
12

13 WHEREAS, there remains a ban on research determining the cause of this disparity, and  
14

15 WHEREAS, Japan, Germany, Australia, and the United Kingdom have developed stricter gun  
16 laws and decreased the homicide rates due to gun violence, and  
17

18 WHEREAS, the United States has no evidence that previously implemented gun control policies  
19 have had a similar effect, and  
20

21 WHEREAS, public health research into motor vehicle accidents and tobacco use has guided  
22 evidence-based interventions and policies to reduce the disease burden from these issues, and  
23

24 WHEREAS, gun violence continues to be a key political issue with significant uncertainty  
25 regarding the best solutions, and  
26

27 WHEREAS, the American Academy of Family Physicians (AAFP) has policies on the prevention  
28 of gun violence, violence as a public health concern, and firearms and safety issues, and  
29

30 WHEREAS, the AAFP has partnered with other organizations to author a letter to US  
31 Representatives and Senators requesting removal of restrictions on gun violence research by  
32 the Centers for Disease Control and Prevention, and  
33

34 WHEREAS, there has still not been action on this issue by the US Congress, now, therefore, be  
35 it  
36

37 RESOLVED, That the American Academy of Family Physicians continue to partner with other  
38 health organizations and the Fam Med PAC to actively lobby for the removal of restrictions on  
39 gun violence research.

1 **RESOLUTION NO. R2-510**

2 **Improving Patient Education of Limited English Proficiency Patients**

3 Introduced by: Sway Wu, Detroit, MI  
4 Katie Zurek, MD, Traverse City, MI  
5 Mike Collins, MD, Flint, MI  
6 Max Weston, MD, Seattle, WA  
7

8 WHEREAS, Fifty-seven million (20%) of the United States population speak a language other  
9 than English at home, and

10  
11 WHEREAS, 25 million (8.6%) of the United States population are defined as limited English  
12 proficiency, and

13  
14 WHEREAS, when professional interpreters are not used at admission or discharge, the length  
15 of hospital stay for patients with limited English proficiency is increased, and

16  
17 WHEREAS, patients limited English proficiency face barriers to medical information  
18 comprehension, now, therefore, be it

19  
20 RESOLVED, That the American Academy of Family Physicians add links such as [ethnomed.org](http://ethnomed.org)  
21 to its official website, and be it further

22  
23 RESOLVED, That the American Academy of Family Physicians provide continuing medical  
24 education at such events as the Family Medicine Experience and National Conference of Family  
25 Residents and Medical Students to educate physicians on providing culturally competent care,  
26 and be it further

27  
28 RESOLVED, That the American Academy of Family Physicians [familydoctor.org](http://familydoctor.org) website  
29 provide more patient information in more languages for physician and patient use.

1 **RESOLUTION NO. R2-511**

2 **Improving Mental Health Care in the Primary Care Setting**

3 Introduced by: Sway Wu, MD, Detroit, MI  
4 Katie Zurek, MD, Traverse City, MI  
5 Michael Collins, MD, Flint, MI  
6 Max Weston, MD, Seattle, WA  
7

8 WHEREAS, 43.8 million (about 20%) of adults in the United States experiences mental illness in  
9 any given year, and

10

11 WHEREAS, only half of the patients with a mental health disorder are diagnosed, and

12

13 WHEREAS, only half of diagnosed patients are effectively treated, and

14

15 WHEREAS, access to mental health care is of significant national public health concern, now,  
16 therefore, be it

17

18 RESOLVED, That the American Academy of Family Physicians provide a liaison to the  
19 American Psychiatric Association to facilitate cohesion between mental health and family  
20 medicine patient care, and be it further

21

22 RESOLVED, That the American Academy of Family Physicians website provide links to the  
23 American Psychiatric Association for physician use in identifying mental health disorders, and  
24 be it further

25

26 RESOLVED, That the American Academy of Family Physicians provide continuing medical  
27 education at such events as Family Medicine Experience and the National Conference of Family  
28 Medicine Residents and Medical Students to improve physician diagnosis of mental health  
29 disorders.

1 **Resolution NO. R2-512**

2 **Offering Guidance to the ABFM Regarding the Maintenance of Certification Family**  
3 **Practice (MC-FP)**

4 Introduced by: Alex Mroszczyk-McDonald, MD, Fontana, CA  
5 Matthew Peters, Boise, ID  
6

7 WHEREAS, The American Academy of Family Physicians (AAFP) member physicians join the  
8 American Board of Family Medicine (ABFM) in supporting lifelong learning that reinforces and  
9 updates medical knowledge critical to patient safety and professional excellence, and  
10

11 WHEREAS, the Winter 2016 ABFM newsletter “The Phoenix” was a welcome indicator of the  
12 ABFM’s openness to listen to and collaborate with physicians in evolving the Maintenance of  
13 Certification for Family Physicians (MC-FP) process to better meet the above mentioned goals,  
14 and  
15

16 WHEREAS, based on current estimates, 60% of family physicians are employed, and  
17

18 WHEREAS, physician employers report Accountable Care Organizations (ACO), meaningful use,  
19 Physician Quality Reporting System (PQRS) and Patient-Centered Medical Home (PCMH) to  
20 payer agencies making Performance in Practice Modules redundant for the majority of family  
21 medicine physicians, and  
22

23 WHEREAS, the current self-assessment activities covering three topics in three years are too  
24 limited and does not reinforce or update the broad range of topics encountered by family  
25 physicians, and  
26

27 WHEREAS, a yearly review of a broad range of topics regularly encountered by family  
28 physicians based on literature from recognized family medicine journals would be more useful,  
29 and  
30

31 WHEREAS, multiple, frequent clinically based assessments over time are more effective  
32 earning opportunities than a single, high-stakes examination, and  
33

34 WHEREAS, family physicians should be free to schedule their MC-FP time commitment, and  
35

36 WHEREAS, the ABFM could simplify Maintenance of Certification (MOC) for physicians by  
37 allowing the AAFP to accredit activities that will count for MOC, and  
38

39 WHEREAS, there is a precedent for such a change as the American Board of Internal Medicine  
40 has recently revised their standards for Maintenance of Certification in partnership with the  
41 Accreditation Council for Continuing Medical Education (ACCME), now, therefore be it  
42

43 RESOLVED, That the American Academy of Family Physicians recommend the American  
44 Board of Family Medicine reevaluate MOC requirements to be more succinct while utilizing  
45 current evidence on adult learning modalities and catering to multiple learning preferences, and  
46 be it further  
47

48 RESOLVED, the American Academy of Family Physicians recommend that the American Board  
49 of Family Medicine allow the AAFP credit system to certify Continuing Medical Education (CME)



50 events as meeting Maintenance of Certification requirements provided they meet mutually  
51 agreed upon standards.

1 **RESOLUTION NO. R2-513**

2 **The American Academy of Family Physicians to Support Accreditation Council for**  
3 **Graduate Medical Education Accredited Residencies in obtaining Osteopathic**  
4 **Recognition**

5 Introduced by: Matthew Varallo, DO, Rancho Mirage, CA  
6 Jeremy Mosher, Vallejo, CA  
7 Stewart Decker, MD, Klamath Falls, OR  
8

9 WHEREAS, The American Osteopathic Association (AOA) and the Accreditation Council for  
10 Graduate Medical Education (ACGME) have signed a memorandum of Understanding to create  
11 a single accreditation system, and  
12

13 WHEREAS, all family medicine residencies will be accredited by the ACGME and AOA  
14 accreditation will no longer exist, and  
15

16 WHEREAS, there is strong evidence that Osteopathic Manipulative Treatment can help to treat  
17 acute low back pain and provides relief of chronic musculoskeletal pain, and  
18

19 WHEREAS, Osteopathic Manipulative Treatment is a sought after skill by both MD and DO  
20 residents to help diagnose and treat musculoskeletal pain, and  
21

22 WHEREAS, residency programs certified with ACGME Osteopathic Recognition would  
23 incorporate training of osteopathic principles to both MD and DO residents, now, therefore, be it  
24

25 RESOLVED, That the American Academy of Family Physician (AAFP) create a statement of  
26 support regarding residency programs seeking to obtain osteopathic recognition, and be it  
27 further  
28

29 RESOLVED, That the American Academy of Family Physician create and make available a  
30 "How to Guide" on how to achieve osteopathic recognition for residency programs and list  
31 mentors available to serve as a resource in the process.  
32

1 **RESOLUTION NO. R2-514**

2 **Talking Explicitly About Impact Bias**

3 Introduced by: Ashlin Mountjoy, Seattle, WA  
4 Jeremy Mosher, Vallejo, CA  
5 Michael Collins, MD, Grand Blanc, MI  
6 Max Weston, MD, Seattle WA  
7

8 WHEREAS, Medical students hold both negative implicit and explicit biases about groups,  
9 which can negatively impact physician-patient interactions, and

10  
11 WHEREAS, high levels of implicit bias among physicians produces more negative interactions  
12 with patients, and

13  
14 WHEREAS, implicit bias interventions can be an effective way to reduce biases, and

15  
16 WHEREAS, while the American Academy of Family Physicians has acknowledged the effects of  
17 racism on health, there are no formal recommendations for addressing this, and

18  
19 WHEREAS, the joint commission has issued an advisory brief with proposed solutions, now,  
20 therefore, be it

21  
22 RESOLVED, That the American Academy of Family Physicians publish a position paper on the  
23 impact of implicit bias in health care, and be it further

24  
25 RESOLVED, That the American Academy of Family Physicians prioritize research on the impact  
26 of implicit bias and effective interventions for reducing implicit bias in healthcare, and be it  
27 further

28  
29 RESOLVED, That the American Academy of Family Physicians (AAFP) as the Accreditation  
30 Council for Graduated Medical Education to consider using AAFP's model curriculum as part of  
31 their accreditation guidelines for family medicine residency programs, and be it further

32  
33 RESOLVED, That the American Academy of Family Physicians (AAFP) as the Liaison  
34 Committee on Medical Education and Commission on Osteopathic College Accreditation to  
35 consider using the AAFP's model curriculum as part of their accreditation guidelines for medical  
36 schools.

1 **RESOLUTION NO. R2-515**

2 **Educating AAFP Constituents on Anti-violence Movements in the Community**

3 Introduced by: Sarah Skog, MD, Portland, OR  
4 Stuart Zeltzer, MD, Klamath Falls, OR

5  
6 WHEREAS, Safety and security are fundamental social determinants of health, and

7  
8 WHEREAS, communities that don't feel safe are denied the foundation necessary for growth,  
9 development and longevity, and

10  
11 WHEREAS, physicians may neglect to address the subject of guns and/or violence further  
12 perpetuating the inequity of safety, and

13  
14 WHEREAS, physicians often don't know or understand current social movements like Black  
15 Lives Matter that fight for social justice and safety, now, therefore, be it

16  
17 RESOLVED, That American Academy of Family Physicians educate its members via its media  
18 channels with periodic reviews of current social anti-violence movements so that members can  
19 better understand their communities and hopefully better address this important public health  
20 issue.

1 **RESOLUTION NO. R2-516**

2 **Resolution in Support of Promoting Health in Trade Agreements**

3 Introduced by: Elizabeth Wiley, MD, JD, MPH, Baltimore, MD  
4 Stewart Decker, MD, Klamath Falls, OR  
5

6 WHEREAS, The U.S. is currently engaged in negotiating a new generation of massive  
7 multilateral trade agreements outside the World Trade Organization (WTO) including the Trans  
8 Pacific Partnership (TPP), and the Transatlantic Trade & Investment Partnership (TTIP) and the  
9 Trade in Services Agreement (TiSA), and  
10

11 WHEREAS, these negotiations are often occur secretly without meaningful civil society  
12 participation and  
13

14 WHEREAS, trade agreement negotiations should be transparent, and  
15

16 WHEREAS, both released and leaked text include provisions detrimental to public health,  
17 access to medicines and the practice of medicine, and  
18

19 WHEREAS, these trade agreements may include Trade-Related Aspects of Intellectual Property  
20 Rights (TRIPS-plus) intellectual property provisions that increase the cost of medications for  
21 patients and may reduce access to medicines in order to increase industry profits, and  
22

23 WHEREAS, these provisions are likely to impact the most vulnerable populations including  
24 United States seniors who face increasingly unsustainable drug prices and delayed access to  
25 low cost generic drugs, and  
26

27 WHEREAS, organizations which represent these patient populations have publicly opposed  
28 intellectual property provisions in the TPP and TTIP which reduce access to medicines, and  
29

30 WHEREAS, Investor-State Dispute Settlement (ISDS) provision in these trade agreements may  
31 enable multinational corporations to challenge evidence-based laws and regulations that protect  
32 public health, and  
33

34 WHEREAS, these trade agreements including the TPP may include provisions that will threaten  
35 environmental protection and environmental health including climate change mitigation and  
36 adaptation commitments, and  
37

38 WHEREAS, physicians and organized medicine has a professional obligation to advocate for  
39 patients and public health in trade agreement negotiations, and  
40

41 WHEREAS, a released TPP text contains an alleged tobacco exemption, such an exemption is  
42 not a true exemption and is unlikely to protect public health regulation from potential challenge  
43 by tobacco companies, and  
44

45 WHEREAS, the AAFP has signed on to letters urging a tobacco exemption in trade agreements  
46 including the TPP, now, therefore, it be  
47

48 RESOLVED, That the American Academy of Family Physicians urge the U.S. Congress and  
49 U.S. Trade Representatives to ensure that trade agreements promote public health, access to

50 medicines and access to care by opposing Investor-State Dispute Settlement (ISDS) and  
51 restrictive intellectual property provisions, and be it further  
52  
53 RESOLVED, That the American Academy of Family Physicians urge the U.S. Trade  
54 Representative (USTR) to ensure transparency and openness in all trade agreement  
55 negotiations including public access to negotiating texts and meaningful opportunities for  
56 stakeholder engagement during agreement negotiations.

1 **RESOLUTION NO. R2-517**

2 **Resident Rotation Exchange**

3 Introduced by: Shivum Agarwal, MD, Fort Worth, TX  
4 Samuel Mathis, MD, Stafford, TX  
5

6 WHEREAS, In a recent survey of Texas family medicine residents, a consistently top-scoring  
7 issue has been the availability of procedural training opportunities in their respective home  
8 programs, and  
9

10 WHEREAS, a struggle of residency programs nationwide is to provide robust experiences in all  
11 aspects of family medicine such as pediatrics, surgical obstetrics, general surgery, outpatient  
12 procedures, etc., and  
13

14 WHEREAS, Medicare data has demonstrated that physicians who provide broader procedural  
15 capabilities significantly lowers cost of care, and, therefore, decreases the financial burden on  
16 our strained medical economic system, and  
17

18 WHEREAS, a broadly held goal of various family medicine authorities and organizations  
19 including the Council of Academic Family Medicine is to develop broadly trained, capable  
20 physicians who can perform a gamut of procedures ranging from laceration repair to  
21 appendectomy, and  
22

23 WHEREAS, in light of recent Society of Teachers of Family Medicine, Lancet and World Health  
24 Organization publications on solutions for global surgical needs, family medicine has been  
25 highlighted as a proposed solution to the global surgical crisis, and  
26

27 WHEREAS, the essential spirit of family medicine is to encourage collaboration over  
28 competition with teamwork over individual accomplishment, now, therefore, be it  
29

30 RESOLVED, That the American Academy of Family Physicians (AAFP) establish an online  
31 rotation exchange program to identify and facilitate contact and communication between  
32 residency programs offering complementary procedural and non-procedural educational training  
33 needs, and be it further  
34

35 RESOLVED, That the American Academy of Family Physicians collaborate with appropriate  
36 governing organizations to create a policy that allows greater flexibility in training such that  
37 residency rotational exchanges may occur without repercussions and minimize administrative  
38 burden for the rotating resident or program, and be it further  
39

40 RESOLVED, That the American Academy of Family Physicians create an agenda item or  
41 commission to explore other innovative means of expanding procedural training in family  
42 medicine.  
43

1 **RESOLUTION NO. R2-518**

2 **Support of Physician Transparency (& Sunshine)**

3 Introduced by: Elizabeth Wiley, MD, JD, MPH, Baltimore, MD  
4 Stewart Decker, MD, Klamath Falls, OR  
5

6 WHEREAS, The Patient Protection and Affordable Care Act included “Sunshine Act” provisions  
7 which mandate reporting of gifts from industry to physicians, and  
8

9 WHEREAS, the profession has not consistently engaged in or promoted transparency, and  
10

11 WHEREAS, the evidence on the effect of any transfer of value to physicians and their  
12 prescribing practices is overwhelming and industry influence on prescribing practices increases  
13 drug costs for both payers and patients, and  
14

15 WHEREAS, transparency on physicians relationships with industry are critical to maintaining the  
16 integrity and credibility of the profession, and  
17

18 WHEREAS, failure to disclose conflicts of interest by a physician should constitute  
19 unprofessional behavior, and  
20

21 WHEREAS, the pharmaceutical and medical device industry invests resources in educational  
22 materials and gifts for physicians because such incentives change prescribing practices and  
23 may undermine evidence-based prescribing and patient safety, and  
24

25 WHEREAS, existing AAFP policy and advocacy has opposed effective implementation of key  
26 Sunshine Act provisions, and  
27

28 WHEREAS, the AAFP has signed on in support of legislation to further expand reporting  
29 exemptions, now, therefore, be it  
30

31 RESOLVED, That the American Academy of Family Physicians support transparency and open  
32 reporting of family physician’s relationships with pharmaceutical and medical device  
33 manufacturers including support of effective and efficient implementation of existing Physician  
34 Payment Sunshine reporting requirements, and be it further  
35

36 RESOLVED, That the American Academy of Family Physicians oppose legislative efforts to  
37 expand current Physician Payment Sunshine exemptions.



1 **RESOLUTION NO. R2-519**

2 **Ending Direct Consumer Advertising**

3 Introduced by: Stewart Decker, MD, Klamath Falls, OR  
4 Redmond Finny, Baltimore, MD  
5

6 WHEREAS, The United States (U.S.) and New Zealand are the only two countries in the world  
7 that allow direct-to-consumer advertising (DTCA) of prescription drugs, and  
8

9 WHEREAS, DTCA spending in the U.S. was \$4.23 billion in 2014, up from 18% from \$3.83  
10 billion in 2013, and  
11

12 WHEREAS, drug spending increased 86% between 1997 and 2001, up about 18% from \$3.83  
13 billion in 2013, and  
14

15 WHEREAS, increases in DTCA between 1999 and 2000 accounted for 12% of drug sales  
16 growth during that period, resulting in an additional \$2.6 billion in drug spending in 2000, and  
17

18 WHEREAS, physicians wrote 34.2% more prescriptions in 1999 than in 1998 for the 25 most  
19 DTCA – promoted drugs, and  
20

21 WHEREAS, physicians wrote only 5.1% more prescriptions for all other prescription drugs, and  
22

23 WHEREAS, the Food and Drug Administration (FDA) is charged with regulation of the accuracy,  
24 honesty, and legality of DTCA but is increasingly unable to do so efficiently due to underfunding  
25 despite expansion of responsibilities, resulting in a decreased number of regulatory letters and  
26 delay in receipt of them (the FDA sees the ads after they air, when the public does), and  
27

28 WHEREAS, 78% of physicians believe their patients understand the possible benefits of  
29 advertised drugs very well or somewhat well but only 40% believe their patients understand the  
30 possible risks, and  
31

32 WHEREAS, 65% of physicians believe DTC ads confuse patients about the relative risks and  
33 benefits of prescription drugs, and  
34

35 WHEREAS, 75% of physicians believed that DTC ad cause patients to think that the drug works  
36 better than it does, and  
37

38 WHEREAS, 58% of physicians agreed strongly that DTC ads make the drugs seem better than  
39 they really are, and  
40

41 WHEREAS, the success or failure of a pharmaceutical should depend on its safety and efficacy  
42 rather than the skill of its marketing team, and  
43

44 WHEREAS, the American television viewer watches as many as nine drug ads a day, totaling  
45 16 hours per year, which far exceeds the amount of time the average individual spends with a  
46 primary care physician, and  
47

48 WHEREAS, in November 2015 the American Medical Association called for “Ban on Direct to  
49 Consumer Advertising of Prescription Drugs and Medical Devices” by convening a physician

50 task force and launching an advocacy campaign to promote prescription drug affordability  
51 through pushes for greater transparency from drug makers in how they price their medicines,  
52 and

53  
54 WHEREAS, The American Academy of Family Physicians (AAFP) policy on DTCA currently  
55 states “The AAFP supports efforts by manufacturers of prescription pharmaceuticals,  
56 nonprescription medications, health care devices and health related products and services to  
57 provide general health information to the public. At the same time, the AAFP urges that any  
58 direct-to-consumer advertising of prescription drugs by pharmaceutical companies be based on  
59 disease state only, without mention of a specific drug by name,” and includes a list of conditions  
60 that must be met to maintain acceptability, now, therefore, be it

61  
62 RESOLVED, The American Academy of Family Physicians change its policy to support a ban  
63 on and/or limitations on direct-to-consumer advertising of prescription drugs and medical  
64 devices, and be it further

65  
66 RESOLVED, That the American Academy of Family Physicians reach out to the American  
67 Medical Association to coordinate on efforts to advocate in support of a ban on and/or limitation  
68 on direct to consumer advertising.  
69

1 **RESOLUTION NO. R2-520**

2 **Against Public Funding of Crisis Pregnancy Centers**

3 Introduced by: Maya Siegel, Baltimore, MD  
4 Naomi Gorfinkle, Baltimore, MD  
5 Redmond Finney, Baltimore, MD  
6 Stewart Decker, MD, Klamath Falls, OR  
7

8 WHEREAS, The importance of the patient-physician relationship is integral to patient health,  
9 trust of physicians, and the health care system as a whole, and  
10

11 WHEREAS, “crisis pregnancy centers” often masquerade as women’s health clinics, misleading  
12 women in relation to their reproductive health, while often not having a physician or nurse on  
13 staff, and  
14

15 WHEREAS, many of these centers choose names similar to women’s health clinics to confuse  
16 patients, and  
17

18 WHEREAS, these centers often try to frighten patients with misleading films or pictures to  
19 influence women seeking abortion care against obtaining an abortion, and  
20

21 WHEREAS, these centers are known to give incomplete or misleading information about  
22 pregnancy options including abortion, adoption, and parenting, and  
23

24 WHEREAS, many states have introduced legislation that would require women to attend these  
25 centers prior to obtaining an abortion, and  
26

27 WHEREAS, these centers have been known to misinform women of their pregnancy status and  
28 dating thereby leading women to think they are earlier along in their pregnancy, and  
29

30 WHEREAS, these efforts to misinform can divert women from accessing comprehensive and  
31 timely care from appropriately trained and licensed medical providers, and  
32

33 WHEREAS, the American Academy of Family Physicians policy states that “the woman  
34 considering an elective abortion should be informed adequately of the potential health risks of  
35 both abortion and continued pregnancy”, and  
36

37 WHEREAS, women who go to one of these centers often feel misled and may lose trust in  
38 medical providers as a whole, and  
39

40 WHEREAS, 12 states provide public funding to these centers, and  
41

42 WHEREAS, 20 states refer women to crisis pregnancy centers or compel physicians to provide  
43 a list of these centers to patients, and  
44

45 WHEREAS, the public funding of these centers indicates a public support of these institutions,  
46 now, therefore, be it  
47

48 RESOLVED, That the American Academy of Family Physicians oppose funding of “crisis  
49 pregnancy centers” at the national level and other organizations that mislead patients to further

50 a political or religious agenda, or to delay them from getting adequate reproductive care, and be  
51 it further

52

53 RESOLVED, That the American Academy of Family Physicians oppose legislation that requires  
54 women to attend crisis pregnancy centers prior to obtaining an abortion or requires physicians  
55 to provide information about crisis pregnancy centers.

1 **RESOLUTION NO. R2-521**

2 **Advocacy for a Federal Ban on Reparative Therapy**

3 Introduced by: Juan Carlos Venis, Muncie, IN  
4 Aisha Harris, Washington, D.C.  
5 Stewart Decker, MD, Klamath Falls, OR  
6 Vivian Jiang, MD, Rochester, NY  
7

8 WHEREAS, Multiple professional societies, including the American Academy of Family  
9 Physicians (AAFP), oppose “conversion therapies,” also known as “reparative” or “ex-gay  
10 therapies,” and their practice on minors in attempts to change their sexual orientation or gender  
11 identity, and  
12

13 WHEREAS, many expert organizations accept sexual orientation and gender identity as  
14 immutable characteristics of an individual, and  
15

16 WHEREAS, multiple studies have demonstrated the harm of such “conversion” practices and  
17 their association with increased risk of depression, substance abuse, high-risk behaviors, and  
18 suicidality, and  
19

20 WHEREAS, youth involuntarily subjected to such practices and poor acceptance from their  
21 families have higher rates of self-harm and suicide, and  
22

23 WHEREAS, the United Nations High Commissioner for Human Rights recommends that  
24 member states ban conversion therapy when forced, or otherwise involuntary, due to breach of  
25 the prohibition on torture and ill-treatment, and  
26

27 WHEREAS, more than 75% of known American lesbian-gay-bisexual-transgender (LGBT)  
28 population lives in states with no laws banning conversion therapy for minors, and  
29

30 WHEREAS, President Obama’s administration supports the banning of such therapies’ use on  
31 minors and there has been considerable public attention drawn to this and similar issues in  
32 recent years, and  
33

34 WHEREAS, United States federal LGBT and child welfare protections as they currently stand  
35 continue to allow these harmful practices by licensed professional, even those state-funded, and  
36

37 WHEREAS, the American public continues to witness the senseless deaths of our queer youth  
38 as a result of these quack practices, and  
39

40 WHEREAS, the AAFP serves to advocate for the health of all children and all Americans  
41 regardless of gender identity or sexual orientation, now, therefore, be it  
42

43 RESOLVED, That the American Academy of Family Physicians actively encourage the United  
44 States Congress to place a federal ban on “reparative therapy” practiced by licensed  
45 professionals on minors and recognize this practice as harmful under federal law.  
46

1 **RESOLUTION NO. R2-522**

2 **Advocacy and Policy Education and Training in Family Medicine Residency Programs**

3 Introduced by: Melissa See, MD, Salt Lake City, UT

4 WHEREAS, Family physicians are positioned to represent and speak on the primary health-care  
5 needs of the communities that they serve, and

6 WHEREAS, family medicine residents are expected to advocate for quality patient care and  
7 optimal patient-care systems per the Accreditation Council for Graduate Medical Education  
8 (ACGME) Program Requirements for Graduate Medical Education in Family Medicine, and

9 WHEREAS, in the Recommended Curriculum Guidelines for Family Medicine Residents  
10 Leadership states, “the resident should demonstrate the ability to apply knowledge of political  
11 advocacy,” and

12 WHEREAS, family physicians are viewed as a critical resource by legislatures when seeking  
13 information on the healthcare needs of their constituents addressing both the needs of patient  
14 care and clinical practice, now, therefore, be it

15 RESOLVED, That the American Academy of Family Physicians (AAFP) support family medicine  
16 residency programs to encourage their residents to engage in advocacy and policy education  
17 and training, and be it further

18 RESOLVED, That the American Academy of Family Physicians (AAFP) strengthen the  
19 educational materials and promotion of materials currently available  
20 on <http://www.aafp.org/advocacy> to address the need for education, training, and skills  
21 development in advocacy and policy during residency.