

HOD ACTION: Council on Medical Education Report 2 adopted as amended and the remainder of the report filed.

## REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-12

Subject: Council on Medical Education Sunset Review of 2002 House Policies

Presented by: David E. Swee, MD, Chair

Referred to: Reference Committee C  
(J. Mack Worthington, MD, Chair)

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1 At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House  
2 policies (Policy G-600.110, AMA Policy Database). Under this mechanism, a policy established  
3 by the House ceases to exist after 10 years unless action is taken by the House to retain it.

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5 The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current,  
6 coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset  
7 mechanism contributes to the ability of the AMA to communicate and promote its policy positions.  
8 It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

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10 At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through  
11 which the policy sunset is conducted. The process now includes the following steps:

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13 1. In the spring of each year, the House policies that are subject to review under the policy  
14 sunset mechanism are identified.  
15 2. Using the areas of expertise of the AMA Councils as a guide, it is determined which  
16 policies should be reviewed by each Council.  
17 3. For the Annual Meeting of the House, each Council develops a separate policy sunset  
18 report that recommends how each policy assigned to it should be handled. For each policy  
19 it reviews, a Council may recommend one of the following actions: (a) retain the policy;  
20 (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for  
21 the recommended action on each policy.  
22 4. The Speakers assign each policy sunset report for consideration by the appropriate  
23 reference committee.

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25 Although the policy sunset review mechanism may not be used to change the meaning of AMA  
26 policies, minor editorial changes can be accomplished through the sunset review process.

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28 The Council on Medical Education's recommendations on the disposition of the 2002 House  
29 policies that were assigned to it are included in the Appendix to this report.

### 30 RECOMMENDATION

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32 The Council on Medical Education recommends that the House of Delegates policies that are listed  
33 in the Appendix to this report be acted upon in the manner indicated, with the exception of H-  
34 305.968, which should be rescinded; H-460.982 (4), which should be revised to delete "into the  
35 1990s"; and H-310.927 (1) (8) (9) (10), which should be retained, and the remainder of this report  
36 be filed.

## APPENDIX – RECOMMENDED ACTIONS ON 2002 HOUSE OF DELEGATES’ POLICIES

<i>Directive/Policy Number</i>	<i>Title</i>	<i>Recommended Action And Rationale</i>
<b>HOUSE OF DELEGATES’ POLICIES</b>		
H-210.980	Physicians and Family Caregivers: Shared Responsibility	Retain. The policy is still relevant.
H-255.971	J-1 Visas and Waivers	Rescind, at the recommendation of AMA-IMG Section staff. The AMA has other policies stating that the Conrad 30 should be permanently authorized and expanded to 50 positions per state.
H-275.932	Internal Medicine Board Certification Report--Interim Report	Retain. The policy is still relevant.
H-275.934	Alternatives to the Federation of State Medical Boards Recommendations on Licensure	Retain, with editorial corrections as noted below, as proposed by staff from the National Board of Osteopathic Medical Examiners. The four references to “Parts” 1 and 2 should be “Levels.” In addition, “COMLEX” is now referred to by its proper name, which is “COMLEX-USA.”
H-295.884	Better Assisting our Patients with Near End of Life Decisions	Rescind. Newer training materials that cover these topics are available. In addition, this policy refers to a 1992 CEJA report; which has been superseded by more recent and relevant policy, including H-295.875 Palliative Care and End-of-Life Care, H-140.977 Residency Training in Medical-Legal Aspects of End-of-Life Care, and H-140.949 Physician-Assisted Suicide.
H-310.927	Resident Physician Working Conditions	Rescind. The definitions in this policy have been superseded by the ACGME Common Program Requirements.
H-360.984	Nursing Shortage	Retain. The policy is still relevant.

H-210.980 Physicians and Family Caregivers: Shared Responsibility

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden; (2) continues to support health policies that facilitate and encourage health care in the home; (3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care; and (4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders. (Res. 308-I-98; Reaffirmation A-02)

H-255.971 J-1 Visas and Waivers

It is the policy of the AMA to: (1) support the Conrad-30 program, a program authorizing states to place 30 physicians annually in either Health Professional Shortage Areas or Medically Underserved Areas, as one of several strategies to help alleviate physician shortages in underserved areas; and (2) recognize that the security interests of the US are of utmost importance and thorough background checks must be conducted on all visa applicants. (BOT Report 11-I-02)

H-275.932 Internal Medicine Board Certification Report--Interim Report

Our AMA opposes the use of recertification or Maintenance of Certification (MOC) as a condition of employment, licensure or reimbursement. (CME Report 7-A-02)

H-275.934 Alternatives to the Federation of State Medical Boards Recommendations on Licensure

Our AMA adopts the following principles: (1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Parts Levels 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Part Level 1 of COMLEX-USA. There should be provision made for students who have not completed Step 2 of the USMLE or Part Level 2 of the COMLEX-USA to do so during the first year of residency training. (2) All applicants for full and unrestricted licensure, whether graduates of US medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the US, have passed all licensing examinations (USMLE or COMLEX-USA), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content. (3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Part Level 1 of COMLEX-USA. (4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians. (5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements. (6) There should be no reporting of actions against medical students to state medical licensing boards. (7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills. (8) The Dean's Letter of Evaluation should be strengthened and standardized, to serve as a

better source of information to residency programs about applicants. (CME Report 8-A-99; Reaffirmed: CME Report 4-I-01; Reaffirmed: CME Report 2-A-11)

**H-295.884 Better Assisting our Patients with Near End of Life Decisions**

Our AMA encourages: (1) the American Association of Medical Colleges and residency program directors to make "Decisions Near the End of Life" an integral part of American undergraduate and graduate medical education; and (2) primary care and psychiatric medicine through their specialty societies to develop joint continuing medical education programs on "Decisions Near the End of Life" open to colleagues from all specialties.

(Resolution 4-A-02)

**H-310.927 Resident Physician Working Conditions**

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

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

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

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

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

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

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

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

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

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

(CME Report 9-A-02)

**H-360.984 Nursing Shortage**

Our AMA supports proposals to increase basic nursing education opportunities, workforce incentives and similar efforts to increase the supply of registered nurses.

(Resolution 313-A-02)