HOD ACTION: Council on Medical Education Report 1 adopted as amended and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-16

Subject: Council on Medical Education Sunset Review of 2006 House Policies

Presented by: Darlyne Menscer, MD, Chair

Referred to: Reference Committee C
(Albert M. Kwan, MD, Chair)

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to exist after 10 years unless action is taken by the House to retain it. The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2012 Annual Meeting, the House amended Policy G-600.110, which now reads as follows:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset "clock," making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification; (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.

3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as

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the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

The Council on Medical Education's recommendations on the disposition of the 2006 House policies that were assigned to it are included in the Appendix to this report.

RECOMMENDATION

The Council on Medical Education recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000 for staff time.

APPENDIX –
RECOMMENDED ACTIONS ON 2006 AND OTHER RELATED HOUSE OF DELEGATES POLICIES

HOUSE OF DELEGATES POLICIES	
Policy Number, Title, Policy	*Recommended Action*
H-040.970 The Uniformed Services University of the Health Sciences The AMA fully supports the continuation of the Uniformed Services University of the Health Sciences as an institution and urges the Executive and Legislative Branches of the United States Government to fulfill their responsibility to our armed forces by fully funding the Uniformed Services University of the Health Sciences. (Res. 315, A-96; Reaffirmed: CME Rep. 2, A-06)	Retain; the USUHS serves the unique needs of the U.S. Armed Forces, so it is important for the AMA to maintain its support for the university's continuation and its full funding.
H-200.952 Diversity in Medical Education Our AMA: (1) commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (2) encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal. (Res. 305, A-06)	Retain; still relevant, but append to H-200.951, Strategies for Enhancing Diversity in the Physician Workforce, as follows: "Our AMA (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities~~.~~; (2) Commends the Institute of Medicine for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; and (3) Encourages medical schools, health care institutions, managed care and other appropriate groups to develop policies articulating the value and importance of diversity as a goal that benefits all participants, and strategies to accomplish that goal.
H-200.953 The Physician Workforce: Recommendations for Policy Implementation AMA policy is that there is now a shortage of physicians, at least in some regions and specialties, and that evidence exists for additional shortages in the future. (CME Rep. 8, A-05; Reaffirmation I-06)	Sunset; superseded by H-200.954, US Physician Shortage, which states, in part, that our AMA "explicitly recognizes the existing shortage of physicians in many specialties and areas of the US."
H-230.966 Physician Appeals Mechanism for Denial of Academic Appointment Hospital governing boards and hospital medical staffs through their Bylaws must remain responsible for medical staff selection. In situations in which	Retain; still relevant.

hospital medical staff privileges are granted by contract on the condition of an academic appointment, the physician must be made aware of and agree to the linkage. Under those circumstances when a physician may lose an academic appointment after full and fair due process, no further action is required for revocation of hospital medical staff privileges. (CME Rep. 8, A-96; Reaffirmed: CME Rep. 2, A-06)	
H-255.977 International Medical Graduates Participation in Medical Societies Our AMA encourages the federation of state, county, and specialty medical societies to identify qualified and interested international medical graduates to be invited, appointed and elected to committees and leadership positions within the House of Medicine. (Res. 217, A-91; Reaffirmed: Sunset Report, I-01; Modified: Res. 616, A-06)	Sunset; superseded by H-255.984, IMG Participation (see below), which is proposed for integration into H-255.988, Report of the Ad Hoc Committee on Foreign Medical Graduates, as part of proposed new item 15.
H-255.984 IMG Participation The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater participation of international medical graduates in leadership positions at all levels of organized medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among International medical graduates.(Sub. Res. 20, I-87; Reaffirmed: CLRPD Rep. 3, I-97; Modified: Res. 616, A-06)	Still relevant, but sunset and integrate into H-255.988, Report of the Ad Hoc Committee on Foreign Medical Graduates, as part of proposed new item 15.
H-255.986 Foreign Medical Graduates in Residency Programs The AMA continues to support the position that those foreign medical graduates who plan to return to their country of origin have the opportunity to obtain graduate medical education in the U.S.(Res. 114, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06)	Still relevant, but sunset and integrate into H-255.988, Report of the Ad Hoc Committee on Foreign Medical Graduates, as part of proposed new item 23.
H-255.988 Report of the Ad Hoc Committee on Foreign Medical Graduates 1. The AMA reaffirms its support of current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada. 2. The AMA continues to support current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE. 3. The AMA reaffirms	Retain; still relevant, with edits as shown for accuracy, current terminology (e.g., IMGs rather than FMGs), and to integrate other relevant policies into a more comprehensive policy. H-255.988 ~~Report of the Ad Hoc Committee on Foreign Medical Graduates~~ AMA Principles on International Medical Graduates Our AMA supports:

its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body. 4. The AMA continues to support cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada. 5. The AMA supports continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. 6. The AMA continues to support working with the ECFMG and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs. 7. The AMA strongly supports the policy that the core clinical curriculum of a foreign medical school should be provided by that school and that U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school. 8. The AMA continues to support working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools. 9. The AMA, in cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care. 10. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs. 11. Special consideration should be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure. 12. The AMA reaffirms its existing policy supporting the use of accreditation standards to enhance the quality of patient care and medical education. Also the AMA opposes the use of such standards for purposes of regulating physician manpower. 13. AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. In particular, these AMA representatives should emphasize that AMA policy does not prohibit the appointment of qualified graduates of foreign medical schools to residency training programs. 14. The AMA	1. ~~The AMA reaffirms its support of~~ ~~c~~Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada. 2. ~~The AMA continues to support~~ ~~c~~Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE. 3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body. 4. ~~The AMA continues to support~~ ~~c~~Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada. 5. ~~The AMA supports c~~Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees. ~~6. The AMA continues to support working with the ECFMG and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.~~ *(Note: Item 6 is already reflected in H-255.966 (3), Abolish Discrimination in Licensure of IMGs, which reads "Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs."* ~~7. The AMA strongly supports the policy that the~~ 6. The core clinical curriculum of a foreign medical school should be provided by that school ~~and that~~; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school. ~~8~~7. W~~w~~orking with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that

reaffirms its support for the requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. 15. The AMA reaffirms and supports publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities. 16. The AMA reaffirms its support of the participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. 17. The AMA encourages the constituent medical societies to support qualified IMGs for nominations to AMA committees and councils. 18. The AMA supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members. 19. The AMA is committed to using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians. 20. The AMA supports demonstrating its interests in issues related to IMGs by publicizing its many relevant resources to all physicians, especially to nonmember IMGs. 21. The AMA supports expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools. 22. The AMA continues to recognize the common aims and goals of all physicians, particularly those practicing in the U.S., and supports making every effort to include all physicians who are permanent residents of the U.S. in the mainstream of American medicine. 23. The AMA is committed to identifying and publicizing resources within the AMA that will respond to inquiries from IMGs. 24. The AMA is committed to providing leadership to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations. 25. The AMA urges institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return. 26. The AMA is committed to informing foreign national IMGs that the availability of training and	institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools. ~~9~~8. ~~The AMA,~~ I~~i~~n cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care. ~~10~~9. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs. ~~11.~~ 10. That ~~S~~special consideration ~~should~~ be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure. ~~12. The AMA reaffirms its existing policy supporting the use of~~ 11. That accreditation standards ~~to~~ enhance the quality of patient care and medical education~~. Also the AMA opposes the use of such standards~~ and not be used for purposes of regulating physician manpower. ~~13.~~ 12. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. *(Note: Language added from H.310-962:* Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor. ~~In particular, these AMA representatives should emphasize that AMA policy does not prohibit the appointment of qualified graduates of foreign medical schools to residency training programs.~~ ~~14.~~ 13. The ~~AMA reaffirms its support for the~~ requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure. ~~15.~~ 14. ~~The AMA reaffirms and supports~~ ~~p~~Publicizing existing policy concerning the granting of staff and clinical privileges in

practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S.	hospitals and other health facilities. ~~16.~~ 15. The ~~AMA reaffirms its support of the~~ participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. *(Note: Language added from H-255.984)* The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs. ~~17. The AMA encourages the constituent medical societies to support qualified IMGs for nominations to AMA committees and councils.~~ *(Note: reflected in language added above)* ~~18~~16~~. The AMA s~~Supports studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members. ~~19.~~17. ~~The~~ AMA membership outreach to IMGs, to include ~~is committed to~~ a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians~~.~~; b) ~~20. The AMA supports demonstrating its interests in issues related to IMGs by~~ publicizing its many relevant resources to all physicians, especially to nonmember IMGs; *(moved from existing 23, below:)* c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) . ~~21. The~~ ~~AMA supports~~ expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools. ~~22.~~ 18. ~~The AMA continues to recognize~~

	Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support~~s making every effort to~~ for include~~e~~ing all physicians who are permanent residents of the U.S. in the mainstream of American medicine.
	(Note: Moved to new 17.c, above) ~~23. The AMA is committed to identifying and publicizing resources within the AMA that will respond to inquiries from IMGs.~~
	~~24.~~ 19. ~~The AMA is committed to providing~~ Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.
	~~25. The AMA urges~~ 20. I~~i~~nstitutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.
	~~26.~~21. ~~The AMA is committed to~~ I~~i~~nforming foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S. *(Note: Language added from H-255.986)*, and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.
	(Note: Language added from H-255.999[6]) 22. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.
	(Note: Language added from H-255.999[7]) 23. Providing U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school.
	(Note: Language added from H-255.999[10]) 24. The Federation of State Medical Boards, its member boards, and the ECFMG in their

	willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
H-255.999 Final Report of the Ad Hoc Committee on Foreign Medical Graduate Affairs Our AMA: (1) Supports actively seeking qualified international medical graduates for nomination or appointment to all the councils of the AMA. (2) Supports the development of a special effort to recruit IMGs for AMA membership. (3) Encourages state medical societies to make an effort to include qualified foreign-trained physicians among their nominees for medical licensing boards. (4) Supports considering appointing a qualified IMG as one of its representatives to the ECFMG Board of Trustees. (5) Encourages state, county and specialty medical organizations to make a special effort to encourage membership and participation by IMGs. (6) Continues its policy that U.S. medical schools offer admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation. (7) Continues to provide U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school. (8) Encourages medical schools to develop special programs for IMGs entering the United States as exchange visitors. These programs should be designed to meet the needs of the country and culture from which the physicians come, as well as the needs of the physicians. (9) Commends and supports the American specialty boards for their interest in evaluating oral examinations and in developing techniques aimed at enhancing the reliability and validity of oral examinations. (10) Commends and supports the Federation of State Boards, its several member boards and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state. (11) Regularly appoint an AMA member, who is an	Still relevant, but sunset and integrate relevant portions into H-255.988, Report of the Ad Hoc Committee on Foreign Medical Graduates, as shown above. Item 1 reflected in proposed new item 15. Item 2 reflected in proposed new items 16 and 17. Item 3 reflected in proposed new item 15. Item 4 reflected in proposed new item 5. Item 5 reflected in proposed new item 15. Item 6 added as proposed new item 22. Item 7 added as proposed new item 23. Item 8 reflected in proposed new item 20. Item 9 is superseded by H-275.924, Maintenance of Certification, which reads, in part, "There should be multiple options for how an assessment could be structured to accommodate different learning styles." Item 10 added as proposed new item 24. Item 11 reflected in proposed new item 5.

international medical graduate, as one of its representatives to the Educational Commission for Foreign Medical Graduates Board of Trustees.	
H-275.979 Medicare Reporting of Adverse Incidents in Hospitals to State Agencies The AMA opposes the sharing of information generated through the Medicare utilization process or other institutional review with state licensure bodies until hospital quality assurance committees have been notified and given a reasonable time to respond. (Res. 118, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06)	Retain; still relevant.
H-275.980 Funding of State Medical Boards (1) The AMA urges state medical associations to recommend to their respective state legislatures that all fees and charges collected by the state licensing/disciplinary board(s), or on its behalf, be specifically designated for use of the board(s) in fulfilling its duties under the state's medical practice act. (2) When such funds are inadequate to support such activities, state general funds should be used to support the board's effective fulfillment of its duties mandated by the state's medical practice act. (Sub. Res. 23, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06)	Retain; still relevant.
H-275.990 Clinical Diagnostic Electromyography The AMA urges appropriate state boards of medical examiners, certification boards, and others to consider the following statement when dealing with the performance of clinical diagnostic electromyography: "Clinical diagnostic electromyographic examinations involving the selection of the muscles to be studied, modifying the examination as the data unfold, inserting the needle electrodes, recording of and interpreting the data thereby obtained, describing the findings, and the rendering of a diagnostic opinion based upon an integration of the clinical history, physical examination features, other pertinent clinical data and the electromyographic findings, should be performed only by a fully licensed physician qualified by reason of education, training, and experience in these procedures."	Retain, still relevant, and edit to incorporate H-275.999, Electromyoneurographic Procedures and D-275.970, Needle Electromyography (both of which are being sunset in this report), to read as follows: ~~The AMA urges appropriate state boards of medical examiners, certification boards, and others to consider the following statement when dealing with the performance of clinical diagnostic electromyography: "~~(1) Clinical diagnostic electromyographic examinations—involving the selection of the muscles to be studied, modifying the examination as the data unfold, inserting the needle electrodes, recording of and interpreting the data thereby obtained, describing the findings, and the rendering of a diagnostic opinion based upon an integration of the clinical history, physical examination features, other pertinent clinical data and the electromyographic findings~~,~~ —is the practice of medicine and should be performed only by a fully licensed physician qualified by reason of education, training, and experience in these procedures.~~"~~ (2) Non-physician health care

	professionals should not expand their scope of practice to include performing needle electromyography. (3) Physicians should not prepare reports and submit claims on needle electromyographic studies that they did not perform or personally supervise. (4) State boards of medical examiners should investigate and take appropriate action whenever cases involving the performance of clinical electromyographic examinations by unqualified persons contrary to the state medical practice act are brought to their attention.
H-275.999 Electromyoneurographic Procedures (1) The term "electromyography" rather than "electromyoneurography" should be used in all communications regarding this subject. (2) The AMA urges state boards of medical examiners to investigate and take appropriate action whenever cases involving the performance of clinical electromyographic examinations by unqualified persons contrary to the state medical practice act are brought to their attention. (CMS Rep. F, A-77; Reaffirmed: CLRPD Rep. C, A-89; Amended by Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06)	Still relevant, but sunset and integrate into H-275.990, Clinical Diagnostic Electromyography for purposes of a more streamlined Policy Finder. The first recommendation does not need to be retained.
H-295.883 Comprehensive Reform at the Interface of Medical Education and Health Care Our AMA expresses its commitment to ensuring the quality of undergraduate, graduate, and continuing medical education. (CME Rep. 6, A-02; Reaffirmed: CME Rep. 3, A-06)	Sunset; superseded by H-295.995, Recommendations for Future Directions for Medical Education, which reads, in part: "(34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels."
H-295.910 Restrictive Covenants During Training The AMA strongly urges residency and fellowship training programs that utilize restrictive covenants to provide written intent to impose such restrictions in advance of the interview process. (Res. 6, I-96; Reaffirmed: CME Rep. 2, A-06)	Sunset; already reflected in ACGME program requirements: "The Sponsoring Institution must maintain a policy which states that neither the Sponsoring Institution nor any of its ACGME-accredited programs will require a resident/fellow to sign a non-competition guarantee or restrictive covenant." Also superseded by H-310.929 (7), Principles for Graduate Medical Education: "Restrictive covenants must not be required of residents or applicants for residency education," H-295.901, Restrictive Covenants in Residency and Fellowship Training Programs: "Our AMA adopts as policy and publicizes to all

	teaching institutions the Current Opinion that it is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians-in-training should not be asked to sign covenants not-to-compete as a condition of their entry into any residency or fellowship program," and H-310.917, Securing Funding for Graduate Medical Education: "3. Our AMA encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs."
H-295.912 Education of Medical Students and Residents about Domestic Violence Screening The AMA will continue its support for the education of medical students and residents on domestic violence by advocating that medical schools and graduate medical education programs educate students and resident physicians to sensitively inquire about family abuse with all patients, when appropriate and as part of a comprehensive history and physical examination, and provide information about the available community resources for the management of the patient. (Res. 303, I-96; Reaffirmed: CME Rep. 2, A-06)	Retain, still relevant.
H-295.913 Hepatitis Vaccinations The AMA will pursue various avenues to assure that all medical students be vaccinated for Hepatitis B at the beginning of their first year of study, or upon entering a residency training program, unless evidence of immunity can be demonstrated. (Sub. Res. 228, A-96; Reaffirmed: CME Rep. 2, A-06)	Sunset; superseded by H-440.958, Universal Immunization for Hepatitis B Virus, which reads, in part: "(2) The AMA encourages the immunization of all students entering medical school. The costs for the immunizations should be included in the school tuition." In addition, this is already reflected in LCME requirements, including 12.7, Immunization Guidelines, which reads: "A medical school follows accepted guidelines in determining immunization requirements for its medical students." Further, 12.8, Student Exposure Policies/Procedures, notes that "A medical school has policies in place that effectively address medical student exposure to infectious and environmental hazards,

	including: The education of medical students about methods of prevention. The procedures for care and treatment after exposure, including a definition of financial responsibility. The effects of infectious and environmental disease or disability on medical student learning activities. All registered medical students (including visiting students) are informed of these policies before undertaking any educational activities that would place them at risk." Hepatitis B is also encompassed in Recommended Vaccines for Healthcare Workers, from the Centers for Disease Control and Prevention: http://www.cdc.gov/vaccines/adults/rec-vac/hcw.html
H-295.915 Residency Program Responsibility for Resident Education The AMA affirms that the basic skills and competencies for the practice of medicine and its specialties must be determined solely by the medical profession. (Res. 313, A-96; Reaffirmed: CME Rep. 2, A-06)	Retain; still relevant.
H-295.916 Improving Medical School/Community Practice (1) Medical schools should be encouraged to include community physicians who serve as volunteer faculty in medical school activities and in committees and other decision-making bodies related to the student educational program, such as the curriculum committee and the admission committee, and in search committees for medical school deans and department chairs. (2) County/state medical societies should be encouraged to include medical school administrators and faculty members in committees and other society activities, and to consider creating a seat for medical school deans in the state society house of delegates. (3) There should be mechanisms established at local or state levels to address tensions arising between the academic and practice communities, such as problems associated with the granting of faculty appointment or hospital staff privileges. (4) The AMA Medical School Visitation Program should be widely publicized and medical schools who have not yet participated should be encouraged to do so. Periodic re-visits should be encouraged. (5) Medical schools and other academic continuing medical education providers should work with community physicians to develop continuing education programs that address local	Retain, still relevant, but delete the following section, as this program is no longer in existence (having been superseded by the AMA's Accelerating Change in Medical Education consortium). ~~(4) The AMA Medical School Visitation Program should be widely publicized and medical schools who have not yet participated should be encouraged to do so. Periodic re-visits should be encouraged.~~ (~~5~~4) Medical schools and other academic continuing medical education providers should work with community physicians to develop continuing education programs that address local needs. (~~6~~5) Community physician groups and schools of medicine should be encouraged to communicate during the initial stages of discussions about the formation of patient care networks.

needs. (6) Community physician groups and schools of medicine should be encouraged to communicate during the initial stages of discussions about the formation of patient care networks. (BOT Rep. 20, A-96; Reaffirmed: CME Rep. 2, A-06)	
H-295.917 Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment The AMA will develop a plan of action to assist and protect medical students in the event of reduction in enrollment or closure of medical schools. (Sub. Res. 310, A-96; Modified and reaffirmed: CME Rep. 2, A-06)	Sunset; superseded by H-295.908, Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment, which reads, “The AMA will continue to monitor medical school closures, mergers, and changes in ownership. In the case of medical school closure or decreases in class size that affect enrolled students, the AMA will provide appropriate assistance, where feasible, so that medical students will experience an orderly transition.”
H-295.969 Nondiscrimination Toward Medical School and Residency Applicants Our AMA urges (1) the Liaison Committee on Medical Education to amend the Standards for Accreditation of Medical Education Programs Leading to the MD Degree, Part 2, Medical Students, Admissions to read: "In addition, there must be no discrimination on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation"; and (2) the Accreditation Council for Graduate Medical Education to amend the "General Essentials of Accredited Residencies, Eligibility and Selection of Residents" to read: "There must be no discrimination on the basis of sex, age, race, creed, national origin, gender identity or sexual orientation."	Retain in part, as follows, with a title change to “Nondiscrimination Toward ~~Medical School and~~ Residency Applicants,” to read as follows: Our AMA urges ~~(1) the Liaison Committee on Medical Education to amend the Standards for Accreditation of Medical Education Programs Leading to the MD Degree, Part 2, Medical Students, Admissions to read: "In addition, there must be no discrimination on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation"; and (2)~~ the Accreditation Council for Graduate Medical Education to amend ~~the "General Essentials of Accredited Residencies, Eligibility and Selection of Residents"~~ its Institutional Requirements to read: "In assessing and selecting applicants for residency/fellowship programs, ACGME-accredited programs ~~There~~ must ~~be~~ not discriminat~~ion~~e on the basis of sex, age, race, creed, national origin, gender identity, or sexual orientation." Item 1 of the policy, covering the LCME, is no longer needed, in that LCME element 3.4 states that “A medical school does not discriminate on the basis of age, creed, gender identity, national origin, race, sex, or sexual orientation.” (Element is the new language for standard.) As for item 2 of the policy, the current ACGME Institutional Requirements, effective July 1, 2015, do not include this

	language, aside from the following, which relates to harassment of resident/fellow physicians who are already in programs, versus discrimination against program applicants, which is the focus of the AMA policy: "IV.H.3. Harassment: The Sponsoring Institution must have a policy, not necessarily GME-specific, covering sexual and other forms of harassment, that allows residents/fellows access to processes to raise and resolve complaints in a safe and non-punitive environment consistent with applicable laws and regulations." Accordingly, this portion of the policy should be maintained, with the noted editorial changes to change the reference from "General Essentials of Accredited Residencies" to "Institutional Requirements," the current terminology.
H-300.951 Credit for Reading Medical Journals The AMA continues to support appropriate credit for medical journal study and make every effort to simplify the process by which this is accomplished. (Res. 315, I-96; Reaffirmed: CME Rep. 2, A-06)	Retain; still relevant.
H-300.952 Dissemination of Information Regarding CME Activities The AMA will continue to support the current system of Continuing Medical Education accreditation in which the Accreditation Council for Continuing Medical Education accredits sponsors whose mission and intended audience are on a regional or national level and state medical societies accredit sponsors whose mission and intended audience are physicians within state and contiguous states, following the guidelines enunciated by the ACCME. (CME Rep. 7, I-96; Reaffirmed: CME Rep. 2, A-06)	Retain; still relevant.
H-300.955 Restructuring of Continuing Medical Education Credits The AMA encourages state licensing boards with CME reporting requirements to allow AMA Physician's Recognition Award Category 1 and Category 2 continuing medical education credit toward reregistration of the license to practice medicine; and all state licensing boards be urged to accept a current and valid AMA Physician's Recognition Award as evidence of completion of these requirements. (CME Rep. 7, A-96; Reaffirmed: CME Rep. 2, A-06)	Retain; still relevant.

H-300.977 Revisions to the Physician's Recognition Award Our AMA has adopted the following changes in the Physician's Recognition Award: (1) to accept recertification by an AMA-recognized specialty board in satisfaction of requirements for a three-year PRA certificate; (2) to allow credit for international conferences when these have been approved by the AMA prior to the event; and (3) to allow credit for teaching to be reported for AMA PRA Category 2 credit toward the award. (CME Rep. D, I-90; Reaffirmed: Sunset Report, I-00; Modified and reaffirmed: CME Rep. 2, A-06)	Retain; still relevant.
H-305.954 Repayment of Medical School Loans Our AMA will further develop and more aggressively publicize a low interest and extended payment loan program for young physician members of the AMA to assist them in retiring their educational debts. (CME Rep. O, A-93; Appended: Res. 610, I-98; Modified: CME Rep. 13, A-06)	Retain; still relevant, with a minor editorial change: "Our AMA will further develop and more aggressively publicize a low interest <u>rate</u> and extended payment loan program for young physician members of the AMA to assist them in retiring their educational debts."
H-305.965 Student Loans Our AMA: (1) reaffirms its support of legislation that would defer the repayment of loans for education until the completion of residency training; and (2) lobby before the next federal budget for deferment of medical student loans for the full initial residency period. (Sub. Res. 203, A-90; Appended Res. 306, I-99; Reaffirmation A-01; Reaffirmation I-06)	Retain; still relevant, but with the following editorial revision, to remove the time certain: "(2) lobby ~~before the next federal budget~~ for deferment of medical student loans for the full initial residency period."
H-310.922 Determining Residents' Salaries Our AMA encourages that residents' level of training, cost of living, and other factors relevant to appropriate compensation be considered by graduate training programs when establishing salaries for residents. (Res. 303, A-06)	Sunset; superseded by H-310.912(2), Residents and Fellows' Bill of Rights:"With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience, and that reflect cost of living differences based on geographical differences."
H-310.923 Eliminating Religious Discrimination from Residency Programs Our AMA encourages residency programs to: (1) make an effort to accommodate residents' religious holidays and observances, provided that patient care and the rights of other residents are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious holidays and observances. (CME Rep. 10, A-06)	Retain; still relevant.

H-310.925 National Resident Matching Program Reform Our AMA supports the National Resident Matching Program as an efficient and effective placement system for filling positions in graduate medical education in the US. (CME Rep. 4, A-05; Reaffirmed: CME Rep. 15, A-06)	Sunset; superseded by more specific policies, including D-310.977, National Resident Matching Program Reform and D-310.974, Policy Suggestions to Improve the National Resident Matching Program.
H-310.937 Impact of Health Care Merging on Residents' Welfare The AMA supports resident representation in negotiation of housestaff contracts and benefits and will take a leadership role and make available staff resources to facilitate the relocation of residents who are displaced abruptly by unexpected residency program closure or downsizing. (CME Rep. 2, I-96; Modified and Reaffirmed: CME Rep. 2, A-06)	Sunset; superseded by H-310.943, Closing of Residency Programs, which reads: "The AMA: (1) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (2) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (3) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (4) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (5) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (6) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (7) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including

	waivers of CMS caps), in the event of temporary or permanent residency program closure.
H-310.962 Residency Programs Prejudiced Against Applicants with Ethnic Names The AMA encourages medical school admissions officers and directors of residency programs to select applicants on the basis of merit, without considering an ethnic name as a negative factor. (Res. 188, A-91; Reaffirmed by Res. 311, A-96; Reaffirmed: CME Rep. 2, A-06)	Still relevant, but sunset and integrate into edits to H-255.988, Report of the Ad Hoc Committee on Foreign Medical Graduates, as part of proposed new item 12.
H-310.982 Reevaluation of Residency Selection Process The AMA supports continued cooperation with the Association of American Medical Colleges in the evaluation of the residency selection process, with emphasis on the reduction of pressures that induce premature specialty decisions within the undergraduate medical curriculum. (Sub. Res. 112, I-86; Amended by Sunset Report, I-96; Modified and Reaffirmed: CME Rep. 2, A-06)	Retain; still relevant.
H-310.983 Residency Positions for Sale The AMA reaffirms its position that selection of residents should be based on the academic and personal qualifications of applicants and that monetary considerations should never compromise the selection process. (CME Rep. A, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06)	Retain; still relevant. This policy is needed in light of concerns about adequate GME positions to meet future health care needs (and as medical school enrollments in the United States continue to expand). In addition, recent attempts to obtain GME funding support from private investors would lend support for retaining this policy.
H-310.986 Education for Residents on Issue of Medical Ethics The AMA believes that the presentation of educational materials on medical ethics should be in all residency training programs. (Sub. Res. 23, I-85; Modified by CLRPD Rep. 2, I-95; Reaffirmed by Sub. Res. 301, A-96; Reaffirmed: CME Rep. 2, A-06)	Sunset; superseded by H-295.961, Medicolegal, Political, Ethical and Economic Medical School Course, which reads, in part: “(1) The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. .. (3) An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification…(5) There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain

	professionalism and high ethical standards. (6) There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school. (7) Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education.
H-390.863 Resolution of DHHS Inspector General Audits of Teaching Physicians Our AMA will join with other interested organizations, such as the Association of American Medical Colleges and the American Hospital Association and with academic medical centers, universities and faculty practice plans, to encourage the Office of the Inspector General (OIG) of the Department of Health and Human Services and the Department of Justice to accept the following principles in dealing with institutions that cooperate with the OIG audits of teaching physicians who have billed through Medicare: (1) That punitive damages be limited to instances in which systematic, fraudulent behavior has been clearly demonstrated. (2) That full reimbursement with interest be accepted for inappropriate Medicare payments that were based on academic institutions' improper interpretation of Intermediary Letter (IL) 372, inadequate documentation, or other inadvertent errors in billing. (Res. 317, I-96; Reaffirmed: CME Rep. 2, A-06)	Sunset; no longer relevant.
H-405.962 The Practice of Public Health by Physicians Our AMA: (1) recognizes the practice of public health by physicians as the practice of medicine; (2) opposes specialty-specific license restrictions for American Board of Medical Specialties (ABMS)-recognized specialties; and (3) encourages the ABMS and the Federation of State Medical Boards to adopt similar policies recognizing the practice of public health by physicians as a legitimate practice of medicine and opposing specialty-specific license restrictions for ABMS-recognized specialties. (Res. 815, I-06)	Retain; still relevant.
H-405.966 Resident Physician Licenses The AMA supports the option of limited educational licenses in all states for resident physicians to provide care within their residency programs; and supports reduced licensure fees for resident physicians for participation solely in graduate	Retain; still relevant.

medical education training programs when full medical licensure is required by a state. (Sub. Res. 312, A-96; Reaffirmed: CME Rep. 2, A-06)	
HOUSE OF DELEGATES DIRECTIVES	
Policy Number, Title, Policy	*Recommended Action*
D-200.986 Impact of Increasing Specialization and Declining Generalism in the Medical Profession Our AMA will: (1) Develop policy regarding the development and maintenance of the appropriate workforce balance between generalists and specialists in its Initiative to Transform Medical Education and in future studies or deliberations related to the medical workforce. (2) Through its Council on Medical Education, continue its close collaborations with the Association of American Medical Colleges, American Board of Medical Specialties, and Accreditation Council for Graduate Medical Education by actively participating in processes which define the content and scope of education and practice, including participation in defining medical school curriculum through the Liaison Committee on Medical Education and reviewing and commenting on proposed changes in the accreditation requirements of Graduate Medical Education programs by the ACGME. (3) Continue to seek input from the Federation on the need for physicians by both geographic region and specialty. (4) Support the concept of partnerships between primary care physicians and patients to coordinate access to all needed medical services and consultations (a “medical home”) for all patients. (5) Encourage physician reimbursement changes which would make generalist physician practice more attractive. (6) Work with the Federation to convene and staff a "medical workforce commission" (which would include representatives of the medical education community, major specialty societies and the public) to project the optimal medical workforce for the US and to develop strategies to achieve that. (CME Rep. 12, A-06; Reaffirmation I-06)	Sunset; no longer relevant or superseded by other AMA policy, such as D-200.979, Barriers to Primary Care as a Medical School Choice; H-295.995, Recommendations for Future Directions for Medical Education; H-295.956, Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers; H-200.972, Primary Care Physicians in the Inner City; D-295.936, Educational Implications of the Medical Home Model; D-35.988, The Joint Commission Primary Care Home Initiative; and H-160.919, Principles of the Patient-Centered Medical Home.
D-200.993 Revisions to AMA Policy on the Physician Workforce Our AMA will, through its Councils, Sections, Minority Affairs Consortium, and other organizations, develop strategies to implement its workforce policy, through research, advocacy, and other relevant means; and collaborate with state and	Sunset; superseded by H-200.955, Revisions to AMA Policy on the Physician Workforce , which reads, in part: “It is AMA policy that: (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system…. (2) Our AMA

specialty societies and other interested groups to develop a national consensus on physician workforce policy. (CME Rep. 2, I-03; Reaffirmation I-06)	encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research. (3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector. (4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians …. (7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career."
D-275.970 Needle Electromyography Our AMA affirms that performing needle electromyography is the practice of medicine, and will work to discourage: (1) other non-physician health care professionals from expanding their scope of practice to include performing needle electromyography; and (2) physicians from preparing reports and submitting claims on needle electromyographic studies that they did not perform or personally supervise.	Still relevant, but sunset and integrate into H-275.990, Clinical Diagnostic Electromyography for purposes of a more streamlined Policy Finder.
D-275.972 Spoken English Proficiency Component of the United States Medical Licensing Examination Our AMA will take no action to request the elimination of the Spoken English Proficiency score from the USMLE Step 2 CS. (CME Rep. 8, A-06)	Sunset; this "directive to take action" calls for no action; assumedly, the inaction was enacted at the time this policy was adopted.
D-295.949 Criminal Background Checks for Medical Students Our AMA will: (1) through relevant Councils and Sections, collaborate with other organizations working to develop policies and procedures for criminal background checks for applicants accepted to medical school and enrolled medical students, including the creation of guidelines for appropriate action related to individuals whose background checks raise concerns; (2) work to ensure that systems for criminal background checks for accepted applicants and medical students are standardized within and across institutions, as well	Retain; still relevant.

as equitable, cost-effective, and consistent with the requirements for background checks being required of resident physicians and practicing physicians; and (3) continue to monitor the requirement for criminal background checks for accepted applicants and medical students by medical schools, hospitals/health systems, and state laws. (CME Rep. 9, A-06)	
D-295.951 Medical Student Clinical Education and Training Conditions: A Follow-up Report on LCME Actions 1. Our AMA encourages the Liaison Committee on Medical Education to continue to monitor compliance with its standard on medical student hours, through its annual survey of medical schools and through its accreditation reviews. If noncompliance with the requirement for medical schools to have policies and practices related to student work load is identified during the annual survey or the accreditation review, the LCME should take timely action to bring schools into compliance. 2. Our AMA will request the Association of American Medical Colleges to add an item to the AAMC Medical School Graduation Questionnaire that asks whether student duty hours were monitored. (CME Rep. 5, A-06)	Sunset; no longer needed. The Liaison Committee on Medical Education assesses clinical duty hours and non-clinical curricular hours, as set forth in the requirement cited below. The LCME also conducts interviews with medical students to assure that hours are reasonable and policies are followed, reviews class schedules, expects schools to have effective mechanisms to monitor and encourage violation reporting, and has cited schools for non-compliance in the past. “8.8 Monitoring Student Workload: The medical school faculty committee responsible for the medical curriculum and the program’s administration and leadership ensure the development and implementation of effective policies and procedures regarding the amount of time medical students spend in required activities, including the total number of hours medical students are required to spend in clinical and educational activities during clerkships.”
D-295.952 Update on the American Medical Association Initiative to Transform Medical Education Our AMA will, through its Initiative to Transform Medical Education, continue to work collaboratively with other organizations to bring about mutually agreed-upon reforms across the continuum of medical education aimed at enhancing physician and health system performance to better meet the health care needs of the public. (CME Rep. 3, A-06)	Sunset; the Initiative to Transform Medical Education is no longer active, having been superseded by the Accelerating Change in Medical Education.
D-305.969 Payment for Graduate Medical Education by the Centers for Medicare and Medicaid Services Our AMA will work with the Association of American Medical Colleges and other interested groups to prevent reduction in Medicare graduate medical education payments by disallowing reimbursement for the time residents spend in	Sunset; superseded by D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, which reads, in part: “6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency

didactic learning. (Res. 317, A-06)	programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.)."
D-480.981 Increasing Awareness of the Benefits and Risks Associated with Complementary and Alternative Medicine Our AMA will promote awareness among medical students and physicians of the wide use of complementary and alternative medicine, including its benefits, risks, and evidence of efficacy or lack thereof. (Sub. Res. 306, A-06)	Sunset; superseded by H-295.902, Alternative Medicine, which reads, in part: "(1) AMA policy states that courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and practice as well as the potential therapeutic utility, safety, and efficacy of these modalities."