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-17

Subject: Council on Medical Education Sunset Review of 2007 House Policies

Presented by: Patricia Turner, MD, Chair

Referred to: Reference Committee C
(Kenneth M. Certa, MD, Chair)

AMA Policy G-600.110, "Sunset Mechanism for AMA Policy," is intended 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. The current policy 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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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 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 2007 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, with the exception of H-295.908, Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment, which should be retained, and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX
RECOMMENDED ACTIONS ON 2007 AND OTHER OR RELATED HOUSE OF DELEGATES POLICIES

HOUSE OF DELEGATES POLICIES	
Policy Number, Title, Policy	*Recommended Action*
H-35.985, AMA Role in Allied Health Education and Accreditation The AMA reaffirms its commitment to promoting quality in allied health education. (CME Rep. E, I-86; Amended by Sunset Report, I-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed in lieu of Res. 705, I-07)	Sunset; the AMA is no longer involved in oversight of allied health education.
H-150.993, **Medical Education in Nutrition** The AMA recommends that instruction on nutrition be included in the curriculum of medical schools in the United States. (Sub. Res. 82, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: CME Rep. 3, I-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; superseded by Basic Courses in Nutrition, H-150.995, which reads, "Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels."
H-150.996, Nutrition Courses in Medicine Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools and that the LCME work toward enhancement of the teaching of nutrition in medical schools. (Sub. Res. 66, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Revise as follows; the excised portion is superseded by H-150.995, Basic Courses in Nutrition. "Nutrition ~~Courses in Medicine~~ Education "Our AMA recommends the teaching of adequate nutrition courses in elementary and high schools~~ and that the LCME work toward enhancement of the teaching of nutrition in medical schools~~."
H-275.941, Out-of-State Residents in Training and State Licensing Board Requirements for Temporary Licenses The AMA will work with the Federation of State Medical Boards (FSMB) to facilitate a timely process so that residents in a training program can meet the licensure requirements to avail themselves of opportunities for educational experiences in states other than that of their primary program location. (Sub. Res. 301, A-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; no longer relevant.
H-275.975, Qualifications of Health Professionals (1) Private certifying organizations should be encouraged to continue certification programs for all health professionals and to communicate to the public the qualifications and standards they require for certification. Decisions concerning recertification should be made by the certifying organizations. (2) Working with state licensing and certifying boards, health care professions should use	Retain; still relevant.

the results of quality assurance activities to ensure that substandard practitioner behavior is dealt with in a professional and timely manner. Licensure and disciplinary boards, in cooperation with their respective professional and occupational associations, should be encouraged to work to identify "deficient Health care professionals. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)	
H-295.870, Medical School Language Electives in Medical School Curriculum Our AMA strongly encourages all Liaison Committee on Medical Education- and American Osteopathic Association-accredited US medical schools to offer medical second languages to their students as electives. (Res. 304, A-07)	Retain; still relevant.
H-295.871, Initiative to Transform Medical Education: Strategies for Medical Education Reform Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role. (CME Rep. 13, A-07)	Retain, still relevant, but with title change as shown below, as this work has been incorporated into the AMA's Accelerating Change in Medical Education strategic focus area. ~~Initiative to Transform~~ Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871
H-295.895, Progress in Medical Education: Structuring the Fourth Year of Medical School It is the policy of the AMA that: (1) Trends toward increasing structure in the fourth year of medical school should be balanced by the need to preserve opportunities for students to engage in elective clinical and other educationally appropriate experiences. (2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training. (3) There should be a comprehensive assessment of clinical skills administered at a time when the results can be used to plan each student's fourth-year program, so as to remedy deficiencies and broaden clinical knowledge. (4) Medical schools should develop policies and procedures to ensure that medical students receive counseling to assist them in their choice of electives. (5) Adequate and timely career counseling should be available at all medical schools. (6) The ability of medical students to choose electives based on interest or perceived academic need should not be compromised by the residency	Retain; still relevant.

selection process. The American Medical Association should work with the Association of American Medical Colleges, medical schools, and residency program directors groups to discourage the practice of excessive audition electives. (7) Our AMA should continue to work with relevant groups to study the transition from the third and fourth years of medical school to residency training, with the goal of ensuring that a continuum exists in the acquisition of clinical knowledge and skills. (CME Rep. 1, I-98; Reaffirmed: CME Rep. 9, A-07)	
H-295.897, Enhancing the Cultural Competence of Physicians 1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula. 2. Our AMA continues research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings. 3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database. 4. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM. 5. Our AMA will seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the	Revise as shown below: 1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula. 2. Our AMA continues <u>to support</u> research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys ~~and focus groups at regularly scheduled meetings~~. ~~3. Our AMA will form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database.~~ ~~4~~<u>3</u>. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through<u>dissemination of currently available resources from the AMA and other relevant organizations.</u>~~development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM.~~

medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice. 6. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments. (CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-11; Appended: Res. 304, I-16)	~~5. Our AMA will seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women's Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice.~~ ~~6~~4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
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. (Sub. Res. 305, I-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; this is reflected in the current institution requirements of the Accreditation Council for Graduate Medical Education.
H-295.903, Opposition to Legislation that Directs the Content of Medical School Curriculum The AMA opposes efforts from all levels of government to dictate the content of medical school curricula either directly or as a condition for receipt of funding. (Res. 322, A-97 Reaffirmed: CME Rep. 2, A-07)	Sunset; superseded by Federal Intervention in the Setting of Educational Standards, H-295.921.
H-295.904, **Commitment to Honor Resident Contracts** The AMA adopts the following language as policy: In the event of a residency program reduction or	Sunset; superseded by Closing of Residency Programs, H-310.943, which reads: "The AMA: (1) encourages the Accreditation Council for Graduate Medical Education

closure, institutions should make every effort possible to allow residents already in the program to complete their education and, should honor the provisions of their existing contracts. (Res. 314, A-97; Reaffirmed: CME Rep. 2, A-07)	(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-295.905, Promoting Culturally Competent Health Care The AMA encourages medical schools to offer electives in culturally competent health care with the goal of increasing awareness and acceptance of cultural differences between patient and provider. (Res. 306, A-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; superseded by Enhancing the Cultural Competence of Physicians, H-295.897.

H-295.908, Protection of Medical Students in the Event of Medical School Closure or Reduction in Enrollment 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. (CME Rep. 4, A-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; this role has been assumed by other organizations.
H-295.914, Instruction in Managed Care The AMA will communicate with medical school deans and residency program directors urging the inclusion in their curricula of appropriate instruction regarding the concept, implementation and impact of managed care on the practice of medicine. (Res. 309, A-96; Reaffirmed by CME Rep. 5, A-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; superseded by Future Directions for Socioeconomic Education, H-295.924, which reads: "The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which 'socioeconomic' subjects are covered in the medical curriculum."
H-295.921, Federal Intervention in the Setting of Educational Standards The AMA strongly opposes federal intervention, through legislative restrictions, that would limit the authority of professional accrediting bodies to design and implement appropriate educational standards for the training of physicians. The AMA strongly opposes infringements and mandates on medical school curricular requirements through state and federal legislative efforts, and also recommends that state medical societies should carefully monitor	Retain; still relevant.

such activities and notify the AMA when such intrusions take place. (Res. 323, A-95; Appended: CME Rep. 4, I-97; Reaffirmed: CME Rep. 2, A-07)	
H-295.922, Establishing Essential Requirements for Medical Education in Substance Abuse AMA policy states that alcohol and other drug abuse education needs to be an integral part of medical education; and that the AMA supports the development of programs to train medical students in the identification, treatment, and prevention of alcoholism and other chemical dependencies. Our AMA: (1) asks all residency review committees to review their training requirements in the treatment and management of substance abuse and addiction and to make recommendations for strengthening this provision as needed; and (2) encourages the development of specialty-specific needs assessment to determine whether targeted educational activities in substance abuse would be useful in their overall program of continuing medical education. (Res. 303, I-94; Reaffirmed and Appended: CME Rep. 10, I-98; Reaffirmed: CME Rep. 11, A-07)	Sunset; superseded by Prescription Drug Diversion, Misuse and Addiction H-95.945, which reads, in part, that our AMA "(5) will promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths." In addition, Substance Use and Substance Use Disorders D-95.984 states that our AMA "(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment…."
H-295.974, Regulation of Medical Student Educational Opportunities The AMA (1) reaffirms its support for the LCME standard for accreditation of undergraduate medical education programs that the curriculum be designed to instill in its graduates the knowledge and skills fundamental to the practice of medicine; and (2) opposes legislation or other efforts by state or federal regulatory agencies to define standards which limit educational opportunities in the training process of future physicians. (Res. 142, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)	Sunset; no longer relevant; item (2) is superseded by Federal Intervention in the Setting of Educational Standards, H-295.921.
H-295.975, Educating Competent and Caring Health Professionals (1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach	Retain; still relevant.

include as an objective the education of practitioners who are both competent and compassionate. (2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities. (3) Faculty of programs of education for the health professions must continue to emphasis than they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced. (4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07)	
H-295.988, Alcohol and Substance Abuse Education of Medical Students and Residents In cooperation with other organizations, the AMA	Sunset; superseded by Prescription Drug Diversion, Misuse and Addiction H-95.945, which reads, in part, that our AMA "(5) will

supports the education of medical students and residents in the prevention and treatment of alcoholism and substance abuse in our nation's youth. (Sub. Res. 100, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 11, A-07)	promote medical school and postgraduate training that incorporates curriculum topics focusing on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education regarding safe medication storage and disposal practices, in order to have future generations of physicians better prepared to contribute to positive solutions to the problems of prescription drug diversion, misuse, addiction and overdose deaths." In addition, Substance Use and Substance Use Disorders D-95.984 states that our AMA "(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment…."
H-300.948, Continuing Medical Education Activities for Procedural Skills The AMA encourages the ACCME to require sponsors of courses in new procedures to provide documentation for physician attendees, using the following four levels of achievement: Level 1: Verification of attendance, Level 2: Verification of satisfactory completion of course objectives, Level 3: Verification of "proctor readiness", and Level 4: Verification of physician competence to perform the procedure. (CME Rep. 12, A-97; Reaffirmed: CME Rep. 2, A-07)	Retain; still relevant.
H-300.949, The Ecology of Medical Education: Physician Self-Directed Learning and Continuing Medical Education The AMA: (1) encourages medical schools and residency programs to define and educate the trainee on principles of self-directed learning, including self-assessment and how to use these principles to achieve continuing professional development; (2) supports efforts of the ACCME to develop ethical guidelines for the providers of CME, recognizing the unique needs of those funding CME and their potential to influence the direction of CME; and (3) will seek support for a national study of the future directions of continuing medical education so that effective strategies and policies are developed for	Retain; still relevant, with the edits shown below. The Standards for Commercial Support have been developed by the ACCME and are in place, so #2 has been accomplished. The AMA: (1) encourages medical schools and residency programs to define and educate the trainee on principles of self-directed learning, including self-assessment and how to use these principles to achieve continuing professional development; and (2) ~~supports efforts of the ACCME to develop ethical guidelines for the providers of CME, recognizing the unique needs of~~

maintaining and improving the competence of physicians in caring for patients. (CME Rep. 10, A-97; Reaffirmed: CME Rep. 2, A-07)	~~those funding CME and their potential to influence the direction of CME; and (3)~~ will seek support for a national study of the future directions of continuing medical education so that effective strategies and policies are developed for maintaining and improving the competence of physicians in caring for patients.
H-305.927, Payment Cuts to Teaching Programs Our AMA opposes payment cuts to any teaching program on the basis that the attending physician is concurrently or sequentially supervising more than one resident, fellow or student. (Sub. Res. 719, I-07)	Retain; still relevant.
H-305.935, Policy Options for Support of Graduate Medical Education Our AMA adopts the following principles: GRADUATE MEDICAL EDUCATION POSITIONS (1) Planning for the number of residency positions should take into account the contributions to patient care made by other health professions and occupations, considering that other health professions and occupations do not substitute for physicians. (2) Explicit immunity from antitrust constraints should be provided to private professional groups, to allow participation in the national debate on the physician workforce. (3) Program quality, based on an assessment of educational program outcomes under the leadership of the Accreditation Council for Graduate Medical Education and its Residency Review Committees, should be a factor in the allocation of funded residency positions. (4) Transitional funds should be provided to teaching institutions that lose residents as a result of cuts in the number of funded positions. (CME Rep. 10, A-99; Reaffirmed: CME Rep. 2, A-00; Modified: CME Rep. 2, I-03; Modified: CME Rep. 7, A-05; Reaffirmation I-07)	Sunset; superseded by other AMA policy, including H-200.955, Revisions to AMA Policy on the Physician Workforce, and H-305.929, Proposed Revisions to AMA Policy on the Financing of Medical Education Programs.
H-310.921, Credentialing Materials: Timely Submission by Residency and Fellowship Programs 1. Our AMA encourages residency programs and fellowship programs to submit credentialing and verification data requested on behalf of their	Sunset; superseded by D-310.965, Credentialing Materials: Timely Submission by Residency and Fellowship Programs.

graduating residents and fellows to the requesting agency within thirty days of the request. 2. Our AMA encourages the Accreditation Council for Graduate Medical Education to establish an accreditation standard for residency and fellowship programs calling for submission of credentialing and recredentialing verification data requested on behalf of their graduating residents and fellows to the requesting agency within thirty days of the request. (Res. 312, A-07)	
H-360.995, **Nursing Education and the Supply of Nursing Personnel in the United States** The AMA supports: (1) all levels of nursing education, at least until the crisis in the supply of bedside care personnel is resolved; (2) government and private initiatives that would facilitate the recruitment and education of nurses to provide care at the bedside; (3) economic and professional incentives to attract and retain high quality individuals to provide bedside nursing care; (4) hospital-based continuing education programs to promote the education of caregivers who assist in the implementation of medical procedures in critical care units, operating and emergency rooms, and medical-surgical care; and (5) cooperation with other organizations concerned with acute and chronic hospital care to develop quality educational programs and methods of accreditation of programs to increase the availability of caregivers at the bedside and to meet the medical needs of the public. (BOT Rep. CC, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CLRPD Rep. 2, A-07)	Sunset; superseded by D-360.998, The Growing Nursing Shortage in the United States.
H-425.988, The US Preventive Services Task Force Guide to Clinical Preventive Services It is the policy of the AMA: (1) to continue to work with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services; and (2) to continue our efforts to develop and encourage continuing medical education programs in preventive medicine. (CME Rep. I, A-90; Reaffirmed by CME Rep. 5, I-95; Reaffirmed and Modified with change in title: CME Rep. 2, A-05; Reaffirmation A-07)	Retain; still relevant.
H-425.991, Support for Preventive Medicine The AMA reaffirms its commitment to preventive medicine. (Res. 135, I-87; Modified: Sunset Report, I-97; Modified and Reaffirmed: CME Rep. 2, A-07)	Sunset; no longer needed, as preventive medicine is a mature specialty field.

HOUSE OF DELEGATES DIRECTIVES	
Policy Number, Title, Policy	*Recommended Action*
D-200.991, The Physician Workforce: Recommendations for Policy Implementation To address current and predicted physician shortages, our AMA will work with members of the Federation and national and regional policymakers to develop mechanisms, including identification of funding sources, to create medical school and residency positions in or adjacent to physician shortage/underserved areas and in undersupplied specialties. (CME Rep. 8, A-05; Reaffirmation I-06; Reaffirmation I-07)	Sunset; superseded by D-305.967(17), The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, which reads as follows: "Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region."
D-220.973, Effective AMA Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage Our AMA: (1) will work with The Joint Commission to consider nurse staffing as a national patient safety goal and to examine the Hospital Accreditation Standards at NR.3.10 (regarding nursing policies and procedures, nursing standards, and nurse staffing plans), LD.3.15 (regarding management of the flow of patients to mitigate patient crowding and ensure appropriate care of patients in temporary locations), and HR.1.10-1.1.20 (regarding the hospital staffing plan and the qualifications of staff), to ensure that nursing staffs are adequate relative to patient number and acuity, are competent, and are appropriately oriented and trained in specialized departments; (2) supports professional nursing associations in their efforts to educate the public and advocate for programs aimed at protecting patient safety by ameliorating the RN shortage in hospitals; (3) encourages hospital organized medical staffs to take steps to improve the working environment and professional standing of nurses in hospitals in order to improve the quality and safety of patient care; (4) will provide reports to the House of Delegates at the 2008, 2009 and 2010 Annual Meetings detailing progress made in its efforts to address the nursing shortage. (Res. 534, A-07)	Sunset, due to directives that are outdated or have been accomplished, or are reflected in other AMA policy. The standards noted in item 1 have been updated multiple times since 2007 and require hospitals to confront staffing shortages. Item 2 is superseded by D-360.998(1), "The Growing Nursing Shortage in the United States," which reads, in part: "Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields." Item 3 is superseded by D-360.998(2)(5), "The Growing Nursing Shortage in the United States," which reads, in part: "Our AMA… (2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients; … (5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in

	nursing and promote better patient care." Item 4 was accomplished by Board of Trustees Report 27-A-08, which resulted in AMA policy H-360.982, "Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage at the Bedside."
D-255.996, ECFMG Representation Our AMA will strongly encourage the ECFMG to regularly appoint an international medical graduate as one of the at-large members on its Board of Trustees. (Res. 304, A-00 Reaffirmed: CME Rep. 2, A-10)	Sunset; directive fulfilled. Also, reflected in AMA Principles on International Medical Graduates H-255.988 (5), which states, in part, "An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees."
D-295.941, Facilitating Access to Health Care Facilities for Training Our AMA will continue to work with the Association of American Medical Colleges and other national organizations to expedite, wherever possible, the standardization of requirements in regards to training on HIPAA, drug screening, and health requirements for medical students, and resident and fellow physicians who are being educated in hospitals and other health care settings. (Res. 811, I-07)	Retain; still relevant.
D-295.946, The Status of Education in Substance Use Disorders in America's Medical Schools and Residency Programs Our AMA will: (1) advocate for in-depth qualitative studies to facilitate the preparation of physicians to care for patients with substance use disorders; (2) facilitate the identification, dissemination, and implementation of successful substance use disorder educational programs across the educational continuum; (3) encourage the Accreditation Council for Graduate Medical Education (ACGME) to include education about substance use disorders in their program accreditation requirements; (4) encourage the American Board of Medical Specialties (ABMS) to encourage its member boards to include substance use disorder questions in their certification process; and (5) through its Council on Medical Education, monitor and track implementation of the recommendations of the December 2006 House Office of National Drug Control Policy White House Leadership Conference on Medical Education in Substance Abuse report. (CME Rep. 11, A-07)	Sunset; items 1 and 2 superseded by D-95.984, Substance Use and Substance Use Disorders; items 3, 4, and 5 accomplished.

D-295.990, Nutritional and Dietetic Education for Medical Students Our AMA will: (1) offer to assist the American Society for Clinical Nutrition in meeting its commitment to ensure that medical schools have appropriate faculty role models to teach clinical nutrition; and (2) identify and disseminate to medical schools new instructional initiatives that heighten the relevance of clinical nutrition content to medical practice. (CME Rep. 1, I-99; Reaffirmed: CME Rep. 2, A-09)	Sunset; superseded by H-150.995, Basic Courses in Nutrition.
D-305.968, CMS to Pay for Residents' Vacation and Sick Leave Our AMA will lobby the Centers for Medicare and Medicaid Services to continue to reimburse the direct and indirect costs of graduate medical education for the time resident physicians are on vacation or sick leave. (Res. 321, A-07)	Retain; still relevant.
D-310.971, The Residency Physician Shortage Reduction Act of 2007 Our AMA will vigorously support in its national legislative activities the passage of pending and future legislation which will increase physician residency positions throughout many states while not undermining existing physician residency positions in any of the states. (Res. 204, A-07); Reaffirmation I-07)	Sunset; refers to a specific piece of legislation, and year. Also, superseded by other AMA policy, such as D-305.958, Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy, which reads, in part: "1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform. "2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US. "3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997. "4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages. "5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians."

	Also superseded by D-305.967, The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education, which reads, in part: "1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others)…. "4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation…. "8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME…. "10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME…. "11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the

	Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs…. "13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians…. "17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region. "18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes. "19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce….