

**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-18

Subject: Council on Medical Education Sunset Review of 2008 House Policies

Presented by: Lynne Kirk, MD, Chair

Referred to: Reference Committee C  
(Sherri S. Baker, MD, Chair)

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1 AMA Policy G-600.110, “Sunset Mechanism for AMA Policy,” is intended to help ensure that the  
2 AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative,  
3 and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to  
4 communicate and promote its policy positions. It also contributes to the efficiency and  
5 effectiveness of House of Delegates deliberations. The current policy reads as follows:  
6

- 7 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A  
8 policy will typically sunset after ten years unless action is taken by the House of Delegates to  
9 retain it. Any action of our AMA House that reaffirms or amends an existing policy position  
10 shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10  
11 years.  
12
- 13 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the  
14 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of  
15 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall  
16 be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been  
17 asked to review policies shall develop and submit a report to the House of Delegates  
18 identifying policies that are scheduled to sunset; (d) For each policy under review, the  
19 reviewing council can recommend one of the following actions: (i) Retain the policy; (ii)  
20 Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent  
21 and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the  
22 reviewing Council shall provide a succinct, but cogent justification; (f) The Speakers shall  
23 determine the best way for the House of Delegates to handle the sunset reports.  
24
- 25 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier  
26 than its 10-year horizon if it is no longer relevant, has been superseded by a more current  
27 policy, or has been accomplished.  
28
- 29 4. The AMA Councils and the House of Delegates should conform to the following guidelines for  
30 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has  
31 been accomplished; or (c) when the policy or directive is part of an established AMA practice  
32 that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA  
33 House of Delegates Reference Manual: Procedures, Policies and Practices.  
34
- 35 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.  
36
- 37 6. Sunset policies will be retained in the AMA historical archives.

1 The Council on Medical Education’s recommendations on the disposition of the 2008 House  
2 policies that were assigned to it are included in the Appendix to this report. Due to their  
3 complexity, and the need for a more thorough consolidation of policy than is available through the  
4 sunset report mechanism, the following policies will be addressed in a Council on Medical  
5 Education report(s) at the 2018 Interim Meeting:

- 6  
7 H-200.956, “Appropriations for Increasing Number of Primary Care Physicians”  
8 H-200.966, “Federal Financial Incentives and Medical Student Career Choice”  
9 H-200.973, “Increasing the Availability of Primary Care Physicians”  
10 H-200.977, “Establishing a National Priority and Appropriate Funding for Increased Training of  
11 Primary Care Physicians”  
12 H-200.978, “Loan Repayment Programs for Primary Care Careers”  
13 H-200.997, “Primary Care”  
14 H-295.956, “Educational Grants for Innovative Programs in Undergraduate and Residency  
15 Training for Primary Care Careers”  
16 H-310.979, “Resident Physician Working Hours and Supervision”  
17 H-310.999, “Guidelines for Housestaff Contracts or Agreements”  
18 D-305.970, “Proposed Revisions to AMA Policy on Medical Student Debt”  
19 D-305.978, “Mechanisms to Reduce Medical Student Debt”  
20 D-305.980, “Immediate Legislative Solutions to Medical Student Debt”

21  
22 RECOMMENDATION

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24 The Council on Medical Education recommends that the House of Delegates policies listed in the  
25 appendix to this report be acted upon in the manner indicated with the exception of H-200.975,  
26 “Availability, Distribution and Need for Family Physicians,” which should be retained, and H-  
27 295.993, “Inclusion of Medical Students and Residents in Medical Society Impaired Physician  
28 Programs,” which should be amended by addition and deletion, to read as follows:

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30 H-295.993, “Inclusion of Medical Students and Residents in Medical Society Impaired Physician  
31 Programs”

32  
33 Our AMA: (1) recognizes the need for ~~(a)~~ appropriate mechanisms to include medical students and  
34 resident physicians in the monitoring and advocacy services of state existing medical society  
35 ~~impaired physician health~~ programs; and ~~(b) these wellness and other programs to include activities~~  
36 to prevent impairment and burnout; and (2) encourages medical school administration and students  
37 to work together to develop creative ways to inform students concerning available student  
38 assistance programs and other related services ~~medical school impairment treatment programs and~~  
39 ~~that schools ensure that these services are provided confidentially.~~ (Directive to Take Action)

Fiscal Note: \$1,000.

APPENDIX  
RECOMMENDED ACTIONS ON 2008 AND OTHER OR RELATED HOUSE OF DELEGATES POLICIES

HOUSE OF DELEGATES POLICIES	
<i>Policy Number, Title, Policy</i>	<i>Recommended Action</i>
<i>H-200.975, "Availability, Distribution and Need for Family Physicians"</i>	
The AMA will continue to recommend specific strategies to increase the availability of primary care physicians, which may include curricular modification, financing mechanisms for medical education and research, financial aid options, and modifications of the practice environment. (Sub. Res. 306, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 2, I-03; Reaffirmation I-08)	Retain; still relevant.
<i>H-250.991, "Support of the AMA Mission in International Medicine"</i>	
The AMA will include the International Medical Graduates Section as a resource for international medical initiatives. (Res. 608, A-98; Reaffirmed: CLRPD Rep. 1, A-08)	Retain; still relevant.
<i>H-255.980, "USMLE Scores not Sole Criteria for Residency Selection"</i>	
Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates' attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicants merit and qualifications. Citation: Res. 143, A-90; Appended Res. 303, I-98; Modified and Reaffirmed: CME Rep. 2, A-08; Modified: Speakers Rep. 01, A-17	Retain; still relevant.
<i>H-275.937, "Patient/Physician Relationship and Medical Licensing Boards"</i>	
(1) Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: Without regard to whether an act or failure to act is entirely determined by a physician, or is the result of a contractual or other relationship with a health care entity, the relationship between a physician and a patient must be based on trust and must be considered	Retain; still relevant, with the editorial change shown below:  (4) Our AMA encourages all state medical societies to advocate for inclusion of the following policy in their state medical licensing board regulations: <u>(1) . . . .</u>

<p>inviolable. Included among the elements of such a relationship of trust are: (a) Open and honest communication between the physician and the patient, including disclosure of all information necessary for the patient to be an informed participant in his or her care.(b)- Commitment of the physician to be an advocate for the patient and for what is best for the patient, without regard to the physician’s personal interests. (c) Provision by the physician of that care which is necessary and appropriate for the condition of the patient and neither more nor less.(d)- Avoidance of any conflict of interest or inappropriate relationships outside of the therapeutic relationship.</p> <p>(2) The relationship between a physician and a patient is fundamental and is not to be constrained or adversely affected by any considerations other than what is best for the patient. The existence of other considerations, including financial or contractual concerns, is and must be secondary to the fundamental relationship.</p> <p>(3) Any act or failure by a physician that violates the trust upon which the relationship is based may place the physician at risk of being found in violation of the Medical Practice Act.</p> <p>(4) The following statement reflects the policy of the (name of state) Board of Medical Examiners regarding the physicians it licenses.</p> <p>(5) A (name of state) physician has both medical-legal and ethical obligations to his or her patients. These are well established in both law and professional tradition. Some models of medical practice may result in an inappropriate restriction of the physician’s ability to practice quality medicine. This may create negative consequences for the public. It is incumbent that physicians take those actions they consider necessary to assure that medical practice models do not adversely affect the care that they render to their patients. (BOT Rep. 30, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	
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*H-275.938, “USMLE Part III and Licensure”*

<p>Our AMA will lobby the Federation of State Medical Boards to discourage states from linking mandatory application for licensure with application to take the USMLE Part III. (Res. 325, A-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain, still relevant, with the following editorial changes: Our AMA will <del>lobby</del> <u>advocate</u> to the Federation of State Medical Boards to discourage states from linking mandatory application for licensure with application to take <del>the</del> USMLE</p>
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	<u>Part III Step 3.</u>
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*H-275.957, “Changing the Grading Policy for Medical Licensure Examinations”*

<p>Our AMA is concerned about the potential for inappropriate use of numerical scores of licensing examinations, particularly as a significant criterion in appointment to residency training programs. Past studies show some residency programs inappropriately use USMLE examination scores in screening their applicants. Our AMA supports the development of mechanisms to ensure confidentiality of the results of licensure exams, and that these results are used only in an appropriate fashion. (BOT Rep. GGG, A-90 Reaffirmed: Sunset Report, I-00 Reaffirmed: CME Rep. 2, A-10)</p>	<p>Sunset; superseded by H-255.980, “USMLE Scores not Sole Criteria for Residency Selection,” as follows:</p> <p>Our AMA (1) urges that the United States Medical Licensing Examination (USMLE) scores not be used as the sole criteria for selecting interns and residents; (2) recommends that residency programs consider all of the candidates’ attributes and qualifications during the selection process; and (3) reaffirms policy that residency appointments should be made solely on the basis of the individual applicants merit and qualifications.”</p>
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*H-275.968, “Recredentialing of Physicians”*

<p>The AMA vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration. (Res. 201, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain through incorporation into H-275.978, “Medical Licensure,” as follows:  <u>(23) vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration.</u></p>
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*H-275.972, “Annual Report of Disciplinary Actions from the Federation of State Medical Boards”*

<p>The AMA supports the Federation of State Medical Boards’ efforts to assure that organizations that use the Federation’s copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards. (Sub. Res. 126, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain through incorporation into H-275.978, “Medical Licensure,” to read as follows:  <u>(24) supports the Federation of State Medical Boards’ efforts to assure that organizations that use the Federation’s copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards.</u></p>
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*H-275.978, “Medical Licensure”*

<p>The AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;                  (2) encourages licensing boards to require a</p>	<p>Revise to incorporate the following relevant policies that are being appended to this policy:                  H-275.968, “Recredentialing of Physicians”                  H-275.972, “Annual Report of Disciplinary Actions from the Federation of State Medical Boards.”</p> <p>The AMA: (1) urges directors of accredited residency training programs to certify the</p>
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<p>certificate of competence for full and unrestricted licensure;</p> <p>(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;</p> <p>(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;</p> <p>(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;</p> <p>(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);</p> <p>(7) urges licensing boards to maintain strict confidentiality of reported information;</p> <p>(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;</p> <p>(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;</p> <p>(10) urges all physicians to participate in continuing medical education as a professional obligation;</p> <p>(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering</p>	<p>clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide certification until they are satisfied that the resident is clinically competent;</p> <p>(2) encourages licensing boards to require a certificate of competence for full and unrestricted licensure;</p> <p>(3) urges licensing boards to review the details of application for initial licensure to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;</p> <p>(4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;</p> <p>(5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses. It is recommended that these regulations permit special purpose licensure with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;</p> <p>(6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine. (BOT Rep. I-93-13; CME Rep. 10 - I-94);</p> <p>(7) urges licensing boards to maintain strict confidentiality of reported information;</p> <p>(8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical licensure and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;</p> <p>(9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse</p>
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<p>the license to practice medicine;</p> <p>(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;</p> <p>(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;</p> <p>(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;</p> <p>(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;</p> <p>(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;</p> <p>(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;</p> <p>(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;</p> <p>(19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;</p> <p>(20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other</p>	<p>consequences to the physician;</p> <p>(10) urges all physicians to participate in continuing medical education as a professional obligation;</p> <p>(11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;</p> <p>(12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;</p> <p>(13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;</p> <p>(14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical licensure regulation;</p> <p>(15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;</p> <p>(16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;</p> <p>(17) urges licensing boards not to place time limits on the acceptability of National Board certification or on scores on the United State Medical Licensing Examination for endorsement of licenses;</p> <p>(18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;</p> <p>(19) urges licensing boards to accept an initial</p>
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<p>licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; and (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license. (CME Rep. A, A-87 Modified: Sunset Report, I-97; Reaffirmation A-04; Reaffirmed: CME Rep. 3, A-10; Reaffirmation I-10; Reaffirmed: CME Rep. 6, A-12 Appended: Res. 305, A-13 Reaffirmed: BOT Rep. 3, I-14)</p>	<p>license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education; (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for licensure by endorsement; (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for licensure by endorsement; <del>and</del> (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license;</p>
	<p><u>(23) vigorously opposes any state or other government agency plan for mandated recredentialing of physicians for the purpose of relicensure or reregistration; and</u></p>
	<p><u>(24) supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards.</u></p>

*H-275.981, "Education in the Professional Discipline Process"*

<p>The AMA (1) urges all state medical associations to recommend that each medical school in its state invite members of the state agency in charge of professional medical conduct to lecture on the topic of professional discipline; and (2) urges each state medical association to recommend that each hospital in its state with a training program invite a member of the state agency in charge of professional medical conduct to disseminate to its housestaff information on the workings of the professional discipline agency. (Res. 8, I-86; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain; still relevant.</p>
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*H-295.869, "Student Loan Empowerment"*

	<p>Retain through incorporation into D-305.993, "Medical School Financing, Tuition, and Student Debt," to read as follows:</p> <ol style="list-style-type: none"> <li>1. The Board of Trustees of our AMA will pursue the introduction of member benefits to help medical students, resident physicians, and young physicians manage and reduce their debt burden. This should include consideration of the feasibility of a developing web-based information on financial planning/debt management; introducing a loan consolidation program, automatic bill collection <del>and</del>, loan repayment programs, and a rotating loan program; and creating an AMA scholarship program funded through philanthropy. The AMA also should collect and disseminate information on available opportunities for medical students and resident physicians to obtain financial aid for emergency and other purposes.</li> <li>2. Our AMA will vigorously advocate for ongoing, adequate funding for federal and state programs that provide scholarship or loan repayment funds in return for service, including funding in return for practice in underserved areas, participation in the military, and participation in academic medicine or clinical research. Obtaining adequate support for the National Health Service Corps and similar programs, tied to the demand for participation in the programs, should be a focus for AMA advocacy efforts.</li> <li>3. Our AMA will collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.</li> <li>4. Our AMA will encourage medical schools to provide yearly financial planning/debt management counseling to medical students.</li> </ol>
<p>Our AMA supports a requirement that medical schools inform students of all government loan opportunities along with private loans, and requires disclosure of reasons that preferred lenders were chosen. (Res. 307, A-08)</p>	<p><u>5. Our AMA supports a requirement that medical schools inform students of all government loan opportunities and requires disclosure of reasons that preferred lenders were chosen.</u></p>
	<p><u>56.</u> Our AMA will urge the Accreditation Council for Graduate Medical Education (ACGME) to revise its Institutional Requirements to include a requirement that financial planning/debt management counseling be provided for resident physicians.</p>

	<p><del>6</del><u>7</u>. Our AMA will work with other organizations, including the Association of American Medical Colleges, residency program directors groups, and members of the Federation, to develop and disseminate standardized information, for example, computer-based modules, on financial planning/debt management for use by medical students, resident physicians, and young physicians.</p> <p><del>7</del><u>8</u>. Our AMA will work with other concerned organizations to promote legislation and regulations with the aims of increasing loan deferment through the period of residency, promoting the expansion of subsidized loan programs, eliminating taxes on aid from service-based programs, and restoring tax deductibility of interest on educational loans.</p> <p><del>8</del><u>9</u>. Our AMA will advocate against putting a monetary cap on federal loan forgiveness programs.</p> <p><del>9</del><u>10</u>. Our AMA will: (a) advocate for maintaining a variety of student loan repayment options to fit the diverse needs of graduates; (b) work with the United States Department of Education to ensure that any cap on loan forgiveness under the Public Service Loan Forgiveness program be at least equal to the principal amount borrowed; and (c) ask the United States Department of Education to include all terms of Public Service Loan Forgiveness in the contractual obligations of the Master Promissory Note.</p> <p><del>10</del><u>11</u>. Our AMA encourages the Accreditation Council for Graduate Medical Education (ACGME) to require programs to include within the terms, conditions, and benefits of appointment to the program (which must be provided to applicants invited to interview, as per ACGME Institutional Requirements) information regarding the Public Service Loan Forgiveness (PSLF) program qualifying status of the employer.</p> <p><del>11</del><u>12</u>. Our AMA will advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility.</p> <p><del>12</del><u>13</u>. Our AMA encourages medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed.</p> <p><del>13</del><u>14</u>. Our AMA encourages medical school</p>
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	<p>financial advisors to promote to medical students service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas.</p> <p>1415. Our AMA will strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.</p>
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*H-295.892, “Potential Implications of Attending Non-LCME/AOA Accredited Medical Education Programs”*

<p>Our AMA encourages efforts to educate all prospective medical students about the potential implications of attending any non-Liaison Committee on Medical Education/American Osteopathic Association accredited medical education program. (Res. 322, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Sunset; superseded by D-295.309, “Promoting and Reaffirming Domestic Medical School Clerkship Education,” which reads in part: “4. AMA policy is that U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA.”</p>
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*H-295.893, “Voting Rights for AMA-MSS NBME Representatives”*

<p>Our AMA will: (1) petition the National Board of Medical Examiners (NBME) to add AMA student representation to the National Board, the governing and voting body of the NBME; and (2) work with the NBME to ensure that the AMA-MSS, through its Governing Council, is given appropriate advance notice of any major upcoming votes. (Res. 323, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 10, A-08)</p>	<p>Sunset; no longer relevant, as this has been accomplished.</p>
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*H-295.894, “Medical Education on Sleep and Sleep Disorders”*

<p>Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education. (Res. 310, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain; still relevant.</p>
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*H-295.896, "Conscience Clause: Final Report"*

<p>Principles to guide exemption of medical students from activities based on conscience include the following:</p> <p>(1) Medical schools should address the various types of conflicts that could arise between a physician's individual conscience and patient wishes or health care institution policies as part of regular curricular discussions of ethical and professional issues.</p> <p>(2) Medical schools should have mechanisms in place that permit students to be excused from activities that violate the students' religious or ethical beliefs. Schools should define and regularly review what general types of activities a student may exempt as a matter of conscience, and what curricular alternatives are required for students who exempt each type of activity.</p> <p>(3) Prospective students should be informed prior to matriculation of the school's policies related to exemption from activities based on conscience.</p> <p>(4) There should be formal written policies that govern the granting of an exemption, including the procedures to obtain an exemption and the mechanism to deal with matters of conscience that are not covered in formal policies.</p> <p>(5) Policies related to exemption based on conscience should be applied consistently.</p> <p>(6) Students should be required to learn the basic content or principles underlying procedures or activities that they exempt. Any exceptions to this principle should be explicitly described by the school.</p> <p>(7) Patient care should not be compromised in permitting students to be excused from participating in a given activity. (CME Rep .9, I-98; Reaffirmed: CEJA Rep. 11, A-08)</p>	<p>Retain; still relevant.</p>
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*H-295.902, "Alternative Medicine"*

<p>(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. (2) Our AMA will work with members of the Federation to convey physicians' and patients' concerns and questions about alternative care to the NIH Office of Alternative Medicine and work with them and other appropriate bodies to address those</p>	<p>Retain; still relevant.</p>
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<p>concerns and questions. (CSA Rep. 12, A-97; Appended by Res. 525, A-98; Reaffirmed: CSAPH Rep. 2, A-08)</p>	
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*H-295.972, "Education Regarding Prescribing Controlled Substances"*

<p>The AMA (1) encourages physicians, hospital medical staff organizations, resident physicians, and medical students to participate in education programs to ensure proper prescribing and dispensing of controlled substances; and (2) encourages regulatory agencies, state medical societies, and state medical boards to recognize the value of participation in such educational programs as an alternative to imposing disciplinary sanctions on well-intentioned physicians. (Sub. Res. 76, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain; still relevant.</p>
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*H-295.993, "Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs"*

<p>Our AMA: (1) recognizes the need for (a) appropriate mechanisms to include medical students and resident physicians in existing medical society impaired physician programs; and (b) these programs to include activities to prevent impairment; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available medical school impairment treatment programs and that schools ensure that these services are provided confidentially. (Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain in part with the additions and deletions shown below.                  Our AMA: (1) recognizes the need for <del>(a)</del> appropriate mechanisms to include medical students and resident physicians in <u>the monitoring and advocacy services of state existing medical society impaired physician health programs</u>; and <del>(b) these wellness and other programs to include activities to prevent impairment and burnout</del>; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available <u>student assistance programs and other related services</u> <del>medical school impairment treatment programs and that schools ensure that these services are provided confidentially.</del></p>
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*H-295.999, "Medical Student Support Groups"*

	<p>Retain through incorporation into H-295.858, "Access to Confidential Health Services for Medical Students and Physicians," as follows:                  1. Our AMA will ask the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, American Osteopathic Association, and Accreditation Council for Graduate Medical Education to encourage medical schools and residency/fellowship</p>
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	<p>programs, respectively, to:</p> <p>A. Provide or facilitate the immediate availability of urgent and emergent access to low-cost, confidential health care, including mental health and substance use disorder counseling services, that: (1) include appropriate follow-up; (2) are outside the trainees' grading and evaluation pathways; and (3) are available (based on patient preference and need for assurance of confidentiality) in reasonable proximity to the education/training site, at an external site, or through telemedicine or other virtual, online means;</p> <p>B. Ensure that residency/fellowship programs are abiding by all duty hour restrictions, as these regulations exist in part to ensure the mental and physical health of trainees;</p> <p>C. Encourage and promote routine health screening among medical students and resident/fellow physicians, and consider designating some segment of already-allocated personal time off (if necessary, during scheduled work hours) specifically for routine health screening and preventive services, including physical, mental, and dental care; and</p> <p>D. Remind trainees and practicing physicians to avail themselves of any needed resources, both within and external to their institution, to provide for their mental and physical health and well-being, as a component of their professional obligation to ensure their own fitness for duty and the need to prioritize patient safety and quality of care by ensuring appropriate self-care, not working when sick, and following generally accepted guidelines for a healthy lifestyle.</p> <p>2. Our AMA will urge state medical boards to refrain from asking applicants about past history of mental health or substance use disorder diagnosis or treatment, and only focus on current impairment by mental illness or addiction, and to accept "safe haven" non-reporting for physicians seeking licensure or relicensure who are undergoing treatment for mental health or addiction issues, to help ensure confidentiality of such treatment for the individual physician while providing assurance of patient safety.</p> <p>3. Our AMA encourages medical schools to create mental health and substance abuse awareness and suicide prevention screening programs that would:</p>
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	<p>A. be available to all medical students on an opt-out basis;</p> <p>B. ensure anonymity, confidentiality, and protection from administrative action;</p> <p>C. provide proactive intervention for identified at-risk students by mental health and addiction professionals; and</p> <p>D. inform students and faculty about personal mental health, substance use and addiction, and other risk factors that may contribute to suicidal ideation.</p> <p>4. Our AMA: (a) encourages state medical boards to consider physical and mental conditions similarly; (b) encourages state medical boards to recognize that the presence of a mental health condition does not necessarily equate with an impaired ability to practice medicine; and (c) encourages state medical societies to advocate that state medical boards not sanction physicians based solely on the presence of a psychiatric disease, irrespective of treatment or behavior.</p> <p>5. Our AMA: (a) encourages study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; (b) encourages medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students; and (c) will work with other interested parties to encourage research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.</p>
<p>1) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty.</p> <p>(2) Our AMA supports making these alternatives available to students at the earliest possible point in their medical education. (Res.</p>	<p><u>6) Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.</u></p>

<p>164, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	
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*H-305.938, “Use of Social Security Numbers in Student Loan Accounts”*

<p>Our AMA will work with student loan servicers and other associated agencies to end the use of Social Security Numbers as account numbers. (Res. 302, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain; still relevant.</p>
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*H-310.935, “The Educational and Work Environment of Resident Physicians”*

<p>AMA policy is that there should be resident organizations in place at institutions that sponsor graduate medical education programs to facilitate the ability of residents to negotiate about issues related to their working environment. (CME Rep. 11, A-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain; although the Accreditation Council for Graduate Medical Education has related policy in its Institutional Requirements, the AMA needs to have policy that addresses the need for residents to be able to negotiate on issues related to their working conditions.</p>
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*H-310.967, “Resident Training in Varied Settings”*

<p>Our AMA reaffirms the inclusion of ambulatory care settings and the participation of community hospitals in graduate medical education. (CME Rep. A, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmation I-08)</p>	<p>Sunset; superseded by H-310.929, “Principles for Graduate Medical Education,” which reads in part:  “(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.”</p> <p>Also reflected in H-305.929, “Proposed Revisions to AMA Policy on the Financing of Medical Education Programs,” which reads in part:  “H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the</p>
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	<p>sites where teaching occurs.”</p> <p>Also reflected in H-295.949, “Encouraging Community Based Medical Education,” which reads: “Our AMA recognizes and acknowledges the vital role of practicing physicians in community hospitals in medical student and resident teaching.”</p> <p>Also reflected in The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967 (26), which reads: “Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.”</p>
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*H-310.973, "Primary Care Residencies in Community Hospitals"*

<p>Our AMA advocates that the Accreditation Council for Graduate Medical Education support primary care residency programs, including community hospital based programs. (Sub. Res. 27, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-08)</p>	<p>Retain; still relevant.</p>
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*H-315.982, "CMS Documentation Guidelines for Teaching Physicians"*

<p>The AMA will work with the CMS to: (1) reduce the redundant and burdensome documentation for teaching physicians; (2) accept documentation by the physician team under the supervision of a teaching physician if it collectively meets all CMS documentation requirements; and (3) accept a statement of the teaching physician's level of participation in patient care as sufficient or adequate documentation. (Res. 861, A-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Retain; still relevant.</p>
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*H-350.979, "Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession"*

<p>Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.                  (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.                  (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.                  (4) Increasing the supply of minority health professionals.</p>	<p>Retain; still relevant.</p>
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<p>(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.</p> <p>(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.</p> <p>(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.</p> <p>(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)</p>	
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*H-360.981, “State Legislative Response to NBME Practice of Using USMLE Step 3 Physician Licensing Exam Questions for Doctors of Nursing Practice Certification”*

	<p>Retain through incorporation into H-35.972, “Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation,” as follows:</p> <ol style="list-style-type: none"> <li>1. It is the policy of our AMA that institutions offering advanced education in the healing arts and professions shall fully and accurately inform applicants and students of the educational programs and degrees offered by an institution and the limitations, if any, on the scope of practice under applicable state law for which the program prepares the student.</li> <li>2. Our AMA disapproves of questions developed for the United States Medical Licensing Examination (USMLE) being used for purposes other than the assessment of physicians-in-training and physicians.</li> <li>3. Our AMA, with the Council of Medical Specialty Societies, and members of the Federation, will continue to work with the National Board of Medical Examiners (NBME) to assure that accurate information continues to be presented in communications about the use of USMLE questions in the Doctor of Nursing Practice (DNP) examination.</li> <li>4. Our AMA, through its representatives to the NBME, will continue to provide feedback as plans for the restructuring of the USMLE are developed and implemented.</li> <li>5. Our AMA will request the NBME to emphasize in future publications that the DNP</li> </ol>
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	<p>certification examination is not for the purposes of licensure of nurses. 6. Our AMA will continue to monitor the use of questions developed for the USMLE and COMLEX by any group for purposes other than the assessment of physicians-in-training and physicians;</p>
<p>AMA policy is that the integrity of the physician (MD/DO) licensure process, through appropriate examination, be maintained so that no person is misled that the training of allied health professionals through their programs or certification is equivalent to the education, skills and training of physicians (MDs/DOs). (Res. 212, I-08)</p>	<p><u>7. Our AMA policy is that the integrity of the physician (MD/DO) licensure process, through appropriate examination, be maintained so that no person is misled that the training of allied health professionals through their programs or certification is equivalent to the education, skills and training of physicians (MDs/DOs).</u> (Res. 211, A-06 Appended: CME Rep. 10, A-10 Modified: CCB/CLRPD Rep. 2, A-14)</p>

*H-360.982, “Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage at the Bedside”*

<p>Our AMA supports:</p> <ol style="list-style-type: none"> <li>1. increased physician awareness of their role in solving the RN shortage at the bedside and the importance of physicians’ participation in efforts to relieve the shortage;</li> <li>2. increased awareness of opportunities for physician leadership and participation in efforts to solve the RN shortage at the bedside;</li> <li>3. physician efforts to identify those models and strategies that are most applicable to their communities and hospitals and, additionally, will produce the best results; and</li> <li>4. national efforts to increase funding for bedside nursing education. (BOT Rep. 27, A-08)</li> </ol>	<p>Sunset; still relevant, but superseded by D-360.998, “The Growing Nursing Shortage in the United States,” which reads:          “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;          (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;          (3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;          (4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;          (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.”</p>
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*H-360.984, "Nursing Shortage"*

<p>Our AMA supports proposals to increase basic nursing education opportunities, workforce incentives and similar efforts to increase the supply of registered nurses. (Res. 313, A-02 Reaffirmed: CME Rep. 2, A-12)</p>	<p>Sunset; superseded by D-360.998, "The Growing Nursing Shortage in the United States."                  In particular, "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...."</p>
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*H-360.999, "Nursing Education"*

<p>The AMA urges that a constructive attitude be assumed by the medical profession at all levels in an attempt to aid those closely concerned with nursing education, to increase the facilities for those training programs, and to aid in recruiting personnel into the training programs. (BOT Rep. D, A-59; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: CLRPD Rep. 1, I-98; Reaffirmed: CME Rep. 2, A-08)</p>	<p>Sunset; superseded by D-360.998, "The Growing Nursing Shortage in the United States." In particular, "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;                  (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....                  (4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;                  (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."</p>
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*H-450.987, "Education of Physicians in Utilization and Quality Review Matters"*

<p>The AMA (1) commends medical schools that provide instruction in quality assurance and utilization review; (2) advocates making available model curriculum information to medical schools wishing to undertake such instruction; (3) reaffirms its support for the provision in the ACGME Program</p>	<p>Sunset; superseded by H-450.994 (5), "Quality Assurance in Health Care," which reads: "Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in clinical graduate training and</p>
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<p>Requirements which requires that residents participate in patient care review activities; and (4) supports and encourages accredited sponsors which currently provide continuing medical education on the subject of quality assurance and utilization review or those which may be interested in developing educational activities for this purpose. (CME Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CME Rep. 2, A-08)</p>	<p>in continuing education programs.”</p>
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<p><b>HOD DIRECTIVES</b></p>	
<p><i>Number, Title, Policy</i></p>	<p><i>Recommended Action</i></p>

<p><i>D-200.985, “Strategies for Enhancing Diversity in the Physician Workforce”</i></p>	
<p>1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.</p> <p>2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.</p> <p>3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.</p> <p>4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.</p>	<p>Retain in part; rescind Item 5, as having been fulfilled by Council on Medical Education Report 5-A-18, “Study of Declining Native American Medical Student Enrollment.”</p>

<p>5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.</p>	<p><del>5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.</del></p>
<p>6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.</p> <p>7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.</p> <p>8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.</p> <p>9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.</p> <p>10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.</p> <p>11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).</p> <p>12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities. (CME Rep. 1, I-06 Reaffirmation I-10 Reaffirmation A-13 Modified: CCB/CLRPD Rep. 2, A-14 Reaffirmation: A-16 Appended: Res. 313, A-17 Appended: Res. 314, A-17)</p>	<p><del>6</del>5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.</p> <p><del>7</del>6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.</p> <p><del>8</del>7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.</p> <p><del>9</del>8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.</p> <p><del>10</del>9. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.</p> <p><del>11</del>10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).</p> <p><del>12</del>11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.</p>

*D-255.980, “Impact of Immigration Barriers on the Nation’s Health”*

<p>1. Our American Medical Association (AMA) recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.</p> <p>2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.</p> <p>3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.</p> <p>4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.</p> <p>5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.</p> <p>6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.</p>	<p>Retain in part; rescind Item 7, as having been fulfilled by Council on Medical Education Report 3-I-17, “Impact of Immigration Barriers on the Nation’s Health.”</p>
<p>7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce. (Alt. Res. 308, A-17)</p>	<p><del>7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.</del></p>

*D-255.983, “Observerships for International Medical Graduates”*

<p>Our AMA will, through its relevant Sections, work with internal and external groups to develop guidelines for observership programs for International Medical Graduates (IMGs) who have received certification by the Educational Commission for Foreign Medical Graduates, including the following: (a) development of a set of educational objectives and a model curriculum outline; and (b) identification of educational/informational materials to address the objectives; and (c) creation of informational materials related to legal, organizational, and operational issues related to program implementation. (CME Rep. 12, A-08)</p>	<p>Sunset; this has been accomplished; see <a href="https://www.ama-assn.org/life-career/establish-observership-international-medical-graduates">https://www.ama-assn.org/life-career/establish-observership-international-medical-graduates</a>.</p>
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*D-275.999, "Board Certification and Discrimination"*

<p>Our AMA will collect information from members discriminated against solely because of lack of American Board of Medical Specialties or equivalent American Osteopathic Board certification (Res. 314, I-98; Reaffirmed: CME Report 2, A-08)</p>	<p>Sunset; the action called for in this policy was addressed in Council on Medical Education Report 2-A-17, "Update on Maintenance of Certification and Osteopathic Continuous Certification (Resolution 315-A-16)," which was adopted in lieu of Resolution 315-A-16, "Maintenance of Certification (MOC) and Licensure (MOL) vs. Board Certification, CME and Life-Long Commitment to Learning." Resolve 2 of Resolution 315-A-16 asked that our AMA "develop an action plan to protect physicians when the Maintenance of Certification is punitively used as a requirement for licensure, credentialing, reimbursement, network participation or employment with a report back at Interim 2016."</p> <p>In response, the report noted: "Currently, MOC is meant to demonstrate proficiency within a chosen discipline, but is not required for state medical licensure. In addition, many hospitals have independently made the decision to require recertification for the granting of privileges, and various quality organizations and insurers use MOC to help identify commitment to professionalism and continuous performance improvement. These requirements are within their legal rights. However, some states are considering or have enacted legislation that prohibits the use of MOC as a criterion for privileging, employment, and reimbursement. Additional data will be needed to determine if an action plan should be developed to protect physicians when MOC is used as a requirement for licensure, credentialing, reimbursement, network participation or employment (Resolution 315-A-16, resolve 2). To date, the Council has not accumulated data on instances where this has occurred. However, when data become available, the Council will determine if these cases fit into a pattern and will advise the HOD on how to proceed."</p> <p>The principles behind this policy are also reflected in H-275.924 (15), "Maintenance of Certification": "15. The MOC program should not be a mandated requirement for licensure, credentialing, recertification, privileging, reimbursement, network participation, employment, or insurance panel participation."</p>
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*D-295.933, "Transparency In Medical Schools' Utilization of Funds From Tuition and Fee Increases"*

<p>Our AMA encourages the development of policies by Liaison Committee on Medical Education- and American Osteopathic Association-accredited medical schools that ensure information on the use of funds from tuition and fee increases is disclosed in a standardized format and in a timely manner to prospective and current medical students. (Sub. Res. 310, A-08)</p>	<p>Sunset. Schools are required to report to the LCME their actual tuition revenues, actual dollars accrued, and the percentage of total institutional revenues resulting from tuition. The complexity of medical school structure and expenditures as well as the diversity of medical school funding sources renders tracking of actual tuition dollars impossible. The LCME does monitor the percentage of total revenues from tuition dollars and expects that tuition revenues are less than 50 percent of total revenues. The LCME also monitors trends in tuition revenues, both actual dollars and the percentage of total revenues. The AOA Commission on Osteopathic College Accreditation monitors similar data among its accredited schools.</p>
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*D-295.936, "Educational Implications of the Medical Home Model"*

<p>Our AMA:          (1) encourages the integration of medical education into Patient-Centered Medical Home (PC-MH) demonstration projects;          (2) will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to review their accreditation standards so as not to impede education in and about the PC-MH model; and          (3) will advocate for funding from all sources for medical schools and residency training programs to provide medical education in the context of PC-MH models. (CME Rep. 4, A-08; Modified: Speakers Rep., I-15)</p>	<p>Sunset; superseded by D-200.979, "Barriers to Primary Care as a Medical School Choice," which reads in part:          "6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) to develop an accreditation environment and novel pathways that promote innovations in training that use progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model. 7. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide graduate medical education for resident physicians and fellows in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 8. Our AMA will advocate for public (federal and state) and private payers to develop enhanced funding and related incentives from all sources to provide undergraduate medical education for students in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model in order to enhance primary care as a career choice. 9. Our</p>
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	<p>AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.”</p> <p>In addition, related to D-295.936(2), LCME standards already allow for clinical educational scenarios that include assignment of medical students to patients’ homes and longitudinal experiences that emphasize continuity of patient care.</p>
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*D-295.938, “Increasing Medical School Class Sizes”*

<p>Our AMA supports increasing the number of medical students, provided that such expansion would not jeopardize the quality of medical education. (Res. 309, A-08)</p>	<p>Retain; still relevant.</p>
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*D-295.939, “Independent Regulation of Physician Licensing Exams”*

<p>Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system in support of Policy H-295.893, “Voting Rights for AMA-MSS NBME Representatives;” (2) continue to collaborate with the organizations who create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). (CME Rep. 10, A-08)</p>	<p>Retain in part, with the deletion shown below, as H-295.893, “Voting Rights for AMA-MSS NBME Representatives,” has been accomplished and is being sunset through this report.</p> <p>Our AMA will: (1) continue to work with the National Board of Medical Examiners to ensure that the AMA is given appropriate advance notice of any major potential changes in the examination system <del>in support of Policy H 295.893, “Voting Rights for AMA MSS NBME Representatives;”</del> (2) continue to collaborate with the organizations that create, validate, monitor, and administer the United States Medical Licensing Examination; (3) continue to promote and disseminate the rules governing USMLE in its publications; (4) continue its dialog with and be supportive of the process of the Committee to Evaluate the USMLE Program (CEUP); and (5) work with American Osteopathic Association and National Board of Osteopathic Medical Examiners to stay apprised of any major potential changes in the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). (CME Rep. 10, A-08)</p>
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*D-295.999, "Extending Impaired Physician Programs to Medical Students"*

<p>Our AMA will inform students of the variety of options available for treatment of impairment, including medical school and state medical society programs. (CME Rep. 4, I-98; Reaffirmed: CME Report 2, A-08)</p>	<p>Sunset; superseded by H-295.863, "Impairment Prevention and Treatment in the Training Years," which reads:          "Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians."          (CCB/CLRPD Rep. 3, A-14)</p>
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*D-300.983, "Financial Conflicts in CME"*

<p>Our AMA will continue to monitor the implementation of the Accreditation Council for Continuing Medical Education 2004 Standards for Commercial Support and report to the House of Delegates any major evidence that these requirements are or are not effective in ensuring the independence of or adversely impact the availability of continuing medical education. (CME Rep. 13, A-08)</p>	<p>Sunset, no longer relevant. The ACCME Standards for Commercial Support have been in place since 2004, and have been adopted by many organizations and societies in the United States and elsewhere in the world. Monitoring is no longer necessary.</p>
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*D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion"*

<p>Our AMA will work to support increased federal funding for training of public health physicians through the Epidemic Intelligence Service program and work to support increased federal funding for preventive medicine residency training programs. (Res. 301, A-08)</p>	<p>Retain; still relevant.</p>
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*D-305.998, "Impact of the Balanced Budget Act of 1997 on Graduate Medical Education Funding in Non-Hospital Settings"*

<p>Our AMA will continue to advocate for additional funds from the federal government and other third party payers for GME programs that take place in non-hospital settings. (BOT Rep. 5, I-98; Reaffirmed: CME Report 2, A-08)</p>	<p>Sunset; superseded by D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," which reads in part:</p> <p>"7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.</p> <p>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."</p> <p>Also reflected in H-305.929, "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," which reads in part:</p> <p>"H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs."</p> <p>Also reflected in H-310.929, "Principles for Graduate Medical Education," which reads in part:</p> <p>"(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty."</p>
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*D-310.962, "Evaluation of Increasing Resident Review Committee Requirements"*

<p>Our AMA will work with and monitor the Accreditation Council for Graduate Medical Education and American Osteopathic Association in studying residency/fellowship documentation requirements for program accreditation and the impact of these documentation requirements on program directors and residents with recommendations for improvement. (Res. 315, A-08)</p>	<p>Retain; still relevant.</p>
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*D-360.994, "State Legislative Response to NBME Practice of Using USMLE Step 3 Physician Licensing Exam Questions for Doctors of Nursing Practice Certification"*

<p>Our AMA, through its Council on Legislation, will work expeditiously to develop and circulate to all state medical and national medical specialty societies, model state legislation that would prohibit the National Board of Medical Examiners from using the past, present or future content of its United States Medical Licensing Examination Step 3 exam, and National Board of Osteopathic Medical Examiners from using the past, present or future content of its COMLEX Step 3 Exam in the certification processes for non-physician providers. (Res. 212, I-08)</p>	<p>Sunset.</p>
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