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-15

Subject: Council on Medical Education Sunset Review of 2005 House Policies

Presented by: William A. McDade, MD, Chair

Referred to: Reference Committee C
(Daniel B. Kimball, Jr., MD, Chair)

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1 At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House
2 policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to
3 exist after 10 years unless action is taken by the House to retain it. The objective of the sunset
4 mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By
5 eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to
6 the ability of the AMA to communicate and promote its policy positions. It also contributes to the
7 efficiency and effectiveness of House of Delegates deliberations.
8
9 At its 2012 Annual Meeting, the House amended Policy G-600.110, which now reads as follows:
10
11 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
12 policy will typically sunset after ten years unless action is taken by the House of Delegates
13 to retain it. Any action of our AMA House that reaffirms or amends an existing policy
14 position shall reset the sunset "clock," making the reaffirmed or amended policy viable for
15 another 10 years.
16
17 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
18 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
19 policies that are subject to review under the policy sunset mechanism; (b) Such policies
20 shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that
21 has been asked to review policies shall develop and submit a report to the House of
22 Delegates identifying policies that are scheduled to sunset; (d) For each policy under
23 review, the reviewing council can recommend one of the following actions: (i) Retain the
24 policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy
25 with more recent and like policy; (e) For each recommendation that it makes to retain a
26 policy in any fashion, the reviewing Council shall provide a succinct, but cogent
27 justification (f) The Speakers shall determine the best way for the House of Delegates to
28 handle the sunset reports.
29
30 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy
31 earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more
32 current policy, or has been accomplished.
33
34 4. The AMA Councils and the House of Delegates should conform to the following
35 guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a
36 policy or directive has been accomplished; or (c) when the policy or directive is part of an
37 established AMA practice that is transparent to the House and codified elsewhere such as

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

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

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

The Council on Medical Education's recommendations on the disposition of the 2005 House policies that were assigned to it are included in the Appendix to this report.

RECOMMENDATION

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

APPENDIX –
RECOMMENDED ACTIONS ON 2005 AND OTHER RELATED HOUSE OF DELEGATES' POLICIES

Policy Number	*Title*	*Recommended Action*
HOUSE OF DELEGATES' POLICIES		
H-045.993	Support of Residencies in Aerospace Medicine	Sunset. There were four residency programs in this subspecialty in 2005, when this 1987 policy was retained; there are five such programs today. AMA policy in support of residency increases in fields of need supersedes the need for specific mention of and support for this field.
H-180.956	Physician Privileges Application - Timely Review by Managed Care	Retain; still relevant.
H-200.983	Health Manpower	Sunset; "Manpower" is an outmoded term, and the AMA has numerous policies that supersede the intent of this policy, including H-200.956, Appropriations for Increasing Number of Primary Care Physicians; H-295.956, Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers; H-200.997, Primary Care; and H-200.977, Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians.
H-220.980	Credentialing Procedure	Retain, still relevant, but edit as noted: "The AMA encourages the ~~JCAHO~~ Joint Commission to continue to monitor medical staff credentialing procedures…"
H-220.989	Physician Credentialing	Retain, still relevant, but edit to read as follows: "The AMA encourages the Joint Commission ~~JCAHO~~ to develop standards …"
H-225.960	Voluntary Use of Hospitalists and Required Consent	Retain; still relevant.
H-225.969	Disputes Between Medical Supervisors and Trainees	Sunset; superseded by Council on Ethical and Judicial Affairs (CEJA) Opinion E-9.055, Disputes Between Medical Supervisors and Trainees.
H-230.964	Physician Credentialing and Privileging	Sunset; superseded by Guidance on New Procedure for CME, available on the AMA website: http://www.ama-assn.org/ama/pub/education-careers/continuing-medical-education/physicians-recognition-award-credit-system/cme-help/guidance-new-procedure-cme.page

H-230.972	Physician Credentialing and Privileging	Sunset; items 1 and 2 are superseded by H-230.964, Physician Credentialing and Privileging, which reads, in part, "Individual character, training, competence, experience, and judgment should continue to be the criteria for granting general or procedure-specific clinical privileges." Item 3 is reflected in Guidance on New Procedure for CME, available on the AMA website. Items 4 and 5 were accomplished.
H-255.989	A Program for Exchange Visitor Physicians	Retain, still relevant; other policies do not address the specific items as listed.
H-255.991	Education for Foreign Physicians	Sunset; superseded by H-255.987, Foreign Medical Graduates, H-255.988, Report of the Ad Hoc Committee on Foreign Medical Graduates, H-250.993, Overseas Medical Education Developed by US Medical Associations, H-255.998, Foreign Medical Graduates, H-255.986, Foreign Medical Graduates in Residency Programs, and H-255.999, Final Report of the Ad Hoc Committee on Foreign Medical Graduate Affairs.
H-295.877	Medical Treatment of Prisoners of War and Detainees	Retain; still relevant.
H-295.879	Improving Sexual History Curriculum in the Medical School	Retain, still relevant, with edits as shown: Our AMA … "(2) supports public messaging ~~the creation of a national public service announcement~~ that encourages patients to discuss concerns related to sexual health with their physician and reinforces its commitment to helping patients maintain sexual health and well-being."
H-295.907	Managed Care and Graduate Medical Education	Retain, still relevant, but edit as noted: 1) "The American Medical Association will encourage ~~AMA representatives to Residency Review Committees and to~~ the Accreditation Council for Graduate Medical Education to ~~request that these bodies~~ review the impact of the changing health care environment…." 2) Revise title as follows, to reflect the policy's content: "The Impact of the Changing Health Care Environment on Graduate Medical Education."
H-295.918	Strengthening Education in Geriatrics	Sunset; superseded by H-295.981, Geriatric Medicine, which reads: "1. Our AMA reaffirms its support for: (a) the incorporation of geriatric medicine into the curricula of medical school departments and its encouragement for further education and

		research on the problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels; and (b) increased training in geriatric pharmacotherapy at the medical student and residency level for all relevant specialties and encourages the Accreditation Council for Graduate Medical Education and the appropriate Residency Review Committees to find ways to incorporate geriatric pharmacotherapy into their current programs. 2. Our AMA recognizes the critical need to ensure that all physicians who care for older adults, across all specialties, are competent in geriatric care, and encourages all appropriate specialty societies to identify and implement the most expedient and effective means to ensure adequate education in geriatrics at the medical school, graduate, and continuing medical education levels for all relevant specialties."
H-295.920	Academic Freedom	Still relevant; rescind and append to H-295.923, Medical Training and Termination of Pregnancy.
H-295.923	Medical Training and Termination of Pregnancy	Retain, with revisions to incorporate H-295.920, which is being sunset in this report, to read as follows: "The AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. Further, the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training."

H-295.926	Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings	Retain with revisions, as shown below: "The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications as needed; (2) encourages that medical schools provide faculty development programs that are designated for *AMA PRA Category 1* ~~c~~*Credit*™; and (3) encourages that teaching continue to be accepted for *AMA PRA Category 2* ~~c~~*Credit*™ when not designated for *AMA PRA Category 1 Credit*™."
H-295.980	Clinical Training in STD for Medical Students/Physicians in Training	Retain; still relevant.
H-300.959	Physician Participation in the AMA Physician's Recognition Award	Retain; still relevant.
H-300.969	Uniform Standards for Continuing Medical Education	Retain; still relevant.
H-300.984	Abuses of the Continuing Medical Education System	Sunset; no longer relevant. The ACCME no longer uses the "Essential Areas and Elements" to accredit CME providers.
H-305.930	Residents' Salaries	Retain; still relevant.
H-305.942	The Ecology of Medical Education: The Infrastructure for Clinical Education	Retain; still relevant.
H-305.948	Direct Loan Consolidation Program	Retain; still relevant.
H-305.971	Discrimination Against Resident Candidates Based on Graduate Medical Education Medicare Funding	Retain, still relevant, but revise to read as follows: "The AMA urges ~~hospitals and~~ residency programs to use the qualifications of residency applicants as a basis for filling available positions, and not the eligibility or level of future ~~status of~~ ~~the~~ Medicare ~~component to~~ graduate medical education funding."
H-305.990	AMA Foundation Scholars Fund	Sunset; no longer relevant. The funding structure has shifted such that monies no longer flow through medical school deans but rather are dispersed directly to the students, obviating the need for the policy.
H-305.991	Repayment of Educational Loans	Retain; still relevant.
H-310.924	Fellowship Application Reform	Sunset; superseded by D-310.958, Fellowship Application Reform, which reads: "Our AMA will: (1) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training; and (2) continue to

		encourage all subspecialties to use the same application cycle and such application cycle should commence only in the final year of residency for programs of less that 5 years, or in the final 2 years of residency for programs of 5 years or longer. (CME Rep. 5, A-09)”
H-310.943	Closing of Residency Programs	Retain; still relevant, but with the following edits, to delete items 2 and 6, as these are already reflected in Accreditation Council for Graduate Medical Education Institutional Requirements, and to add items 4 and 7, to incorporate items 2 and 4 from D-310.972, Protection Against Delayed Residency Program Closure, which is being sunset in this report: “The AMA: (1) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; ~~(2) encourages the ACGME to develop guidelines for the institution to follow in such closings or reductions that provide for adequate notification and out-placement service (such as resource contacts, transfer assistance, and financial assistance);~~ (~~3~~2) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (~~4~~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 undo stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements;

		~~(6) urges institutions that initiate significant reductions in graduate medical education programs (in excess of 20 percent of the trainee complement or in excess of 10 percent of trainees for a given year), or that voluntarily close programs, be requested prior to or at the time of the reduction to file a concise summary of its educational impact with the Accreditation Council for Graduate Medical Education or the relevant Residency Review Committees; and~~ (~~7~~6) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding~~.~~; and (7) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure."
H-310.988	Adequate Resident Compensation	Retain; still relevant.
H-310.991	Assistance in Completion of Residency Programs	Sunset; superseded by H-310.943, Closing of Residency Programs.
H-310.993	Resident Participation on Hospital Committees	Retain; still relevant.
H-310.994	Curriculum Orientation of Medical Staff Membership in Teaching Programs	Retain; still relevant.
H-310.995	Anonymity for Resident Inquiries to Residency Review Committees	Retain; still relevant.
H-350.963	Minority Physician Recruitment	Sunset; superseded by H-350.969, Medical Education for Members in Underserved Minority Populations.
H-365.995	Competence in Occupational Medicine of Hospital-Based Physicians Assigned to Occupational Medicine Practice	Sunset; no longer relevant.
H-405.965	Essentials for Approval of Examining Boards in Medical Specialties	Sunset; superseded by D-275.973, Essentials for Approval of Examining Boards in Medical Specialties.
H-405.995	Administration and Supervision of Rehabilitation Units	Retain; still relevant.
H-425.982	Training in the Principles of Population-Based Medicine	Retain; still relevant, with edit as shown, as the AMA is not currently developing such initiatives: "The AMA will continue to

		monitor and support the progress made by medical and public health organizations in championing disease prevention and health promotion; and will support efforts ~~continue to develop initiatives~~ to bring schools of medicine and public health back into a closer relationship.”
H-435.954	Impact of US Medical Liability Premiums on Clinical Medical Education	Retain; still relevant.
H-440.969	Meeting Public Health Care Needs Through Health Professions Education	Retain; still relevant.
H-460.989	Animals as Experimental Subjects	Retain; still relevant.
H-475.985	Protecting the Integrity of General Surgery as a Specialty	Retain; still relevant.
H-480.988	Allocation of Privileges to Use Health Care Technologies	Retain; still relevant.
HOUSE OF DELEGATES’ DIRECTIVES		
D-255.989	Expeditious Security Clearance and Visa Processing of Physicians	Sunset; superseded by H-255.988, Report of the Ad Hoc Committee on Foreign Medical Graduates and D-255.991, Visa Complications for IMGs in GME.
D-275.973	Essentials for Approval of Examining Boards in Medical Specialties	Retain; still relevant.
D-275.975	Sharing of Medical Disciplinary Data Among Nations	Retain; the International Association of Medical Regulatory Authorities is still active in this area and has several policy statements on data sharing. The FSMB is also a member of this association and acts as its secretariat.
D-295.954	Teaching and Evaluating Professionalism in Medical Schools	Sunset. Directive #1 has already been fulfilled by the LCME, through accreditation standard MS-31-A, which expects medical schools to define the professional attributes that students are required to develop and to assess medical students’ attainment of these attributes; and Standard MS-32, which asks schools to define standards of conduct in the teacher-student relationship and to monitor violations of these standards by students, faculty, residents, and others in the learning environment. Directive #2 has also been fulfilled by the LCME: Accreditation standards are reviewed at least every five years, by LCME policy, and schools are reviewed using the standards at least every eight years. Directive #3 is superseded by H-295.961 (3), Medicolegal, Political, Ethical

		and Economic Medical School Course, which reads, in part, "An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification." Directive #4 is outside the purview of the AMA. Directive #5 is not needed; these organizations have not attempted to develop a fee-based professionalism examination.
D-295.955	Educating Medical Students about the Pharmaceutical Industry	Sunset; this directive was accomplished through dissemination of this information to the medical education community.
D-295.957	Medical Student and Resident Physician Education about Pharmaceutical Advertising to Health Professionals	Sunset; the CEJA opinions under which this directive was based have been superseded by more recent opinion, and the AMA curriculum that is referenced, "What You Should Know About Gifts to Physicians From Industry," is no longer available.
D-310.972	Protection Against Delayed Residency Program Closure	Sunset; items 1 and 3 are already policy of the Accreditation Council for Graduate Medical Education; items 2 and 4 are being incorporated into H-310.943, Closing of Residency Programs (in this report).
D-310.976	Negative Impact on Surgical and Procedural Education from Revised CMS Interpretive Guidelines for Informed Consent	Sunset; this directive was accomplished by communication from the AMA to the organizations noted.
D-435.979	Impact of US Medical Liability Premiums on Clinical Medical Education	Sunset; superseded by H-435.954, Impact of US Medical Liability Premiums on Clinical Medical Education.

HOUSE OF DELEGATES' POLICIES

H-045.993, Support of Residencies in Aerospace Medicine
The AMA offers its encouragement and assistance to the Congress, the Executive Office, NASA, the Department of Defense, and the FAA in providing support to residency training programs in aerospace medicine. (Res. 19, I-87; Reaffirmed: CME Rep. 2, A-05)

H-180.956, Physician Privileges Application - Timely Review by Managed Care
Our AMA policy is that:(1) final acceptance of residents who otherwise are approved by a health plan should be contingent upon the receipt of a letter from their program director stating that their training has been satisfactorily completed; (2) health plans which require board certification should allow the completing resident to be included in their plan after showing evidence of having completed the required training and of working towards fulfilling the requirements in the time frame established by their respective Board for completion of certification; and (3) Medicare, Medicaid, and managed care organizations should (a) make final physician credentialing

determinations within 45 calendar days of receipt of a completed application; (b) grant provisional credentialing pending a final credentialing decision if the credentialing process exceeds 45 calendar days; and (c) retroactively compensate physicians for services rendered from the date of their credentialing. (Res. 708, A-01; Modified Sub. Res. 701, I-01; Reaffirmed: Res. 809, I-02; Reaffirmation A-05)

H-200.983, Health Manpower

It is the policy of the AMA to (1) use its influence to convince the Administration and Congress of the continuing need for federal support for the education and training of primary care physicians, including reauthorization of federal programs under Title VII to help meet manpower requirements for primary care physicians; and (2) use its influence to encourage federal funding to promote educational and training opportunities for primary care and increase the field strength of the NHSC in medically underserved urban and rural areas. (Res. 112, I-90; Reaffirmed: BOT Rep. GG, I-92; Reaffirmed: CME Rep. 2, A-03; Modified: CME Rep. 7, A-05)

H-220.980, Credentialing Procedure

The AMA encourages the JCAHO to continue to monitor medical staff credentialing procedures to include clearly delineated authority to an elected physician of the medical staff for access, review and judgment over contents, to ensure that the individual medical staff member's credentials file contains only well documented and appropriate data and does not include information that is immaterial, misleading or of questionable value. (BOT Rep. C, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CLRPD Rep. 1, A-05)

H-220.989, Physician Credentialing

The AMA encourages the JCAHO to develop standards that permit hospital medical staffs to establish educational needs as one of the criteria for medical staff privileges in teaching hospitals, to assure an appropriate number and variety of patients for educational purposes. (Sub. Res. 82, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-225.960, Voluntary Use of Hospitalists and Required Consent

It is the policy of our AMA that the use of a hospitalist physician as the physician of record during a hospitalization must be voluntary and the assignment of responsibility to the hospitalist physician must be based on the consent of the patient's personal physician and the patient. (CME Rep. 2, A-99; Reaffirmation I-99; Reaffirmed: Res. 812, A-02; Reaffirmed with change in title: BOT Rep. 15, A-05; Reaffirmed in lieu of Res. 734, A-05)

H-225.969, Disputes Between Medical Supervisors and Trainees

The AMA has adopted the following guidelines with regard to disputes between medical supervisors and trainees: (1) Clear policies for handling complaints from medical students, resident physicians, or other staff should be established, as outlined in the recommendations of the AMA's Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures and Council on Ethical and Judicial Affairs (CEJA) Opinion 9.031; "Reporting Impaired, Incompetent or Unethical Colleagues." Grievance Committees or other mechanisms for handling complaints should provide for participation by peers of the medical student or resident physician complainant. (2) Policies for handling complaints should include adequate provisions for protecting the confidentiality of complainants when possible. Retaliatory or punitive actions against those who raise complaints are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee. (3) Mechanisms for adjudicating disputes requiring immediate resolution should be in place. Disputes requiring immediate resolution are defined as those involving serious errors in clinical or ethical judgment, or physician impairment, that result in a threat of imminent harm to the patient or to others. Third party mediators of such disputes may include the chief of

staff or the involved service, the chief resident, a designated member of the institutional grievance committee, or, in large institutions, an institutional ombudsperson largely outside of the established hospital staff hierarchy. (4) In accordance with item 3, medical students, resident physicians, and other staff should refuse to participate in patient care ordered by their supervisors in those rare cases in which the orders reflect serious errors in clinical or ethical judgment, or physician impairment, that result in a threat of imminent harm to the patient. In these rare cases, the complainant may withdraw from the care ordered by the supervisor, provided that withdrawal does not itself threaten the patient's immediate welfare. In any event, it is essential that the student, resident physician, or staff member communicate his or her concerns to the physician issuing the orders and, if necessary, to the appropriate persons for mediating disputes requiring immediate resolution, as defined in item 3 above. Retaliatory or punitive actions against complainants are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee. (5) Access to employment and evaluation files should be carefully monitored to remove the possibility of inappropriate alteration or tampering. Resident physicians should be permitted access to their employment files and also the right to copy the contents thereof, within the provisions of applicable federal and state laws. (CEJA Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-230.964, Physician Credentialing and Privileging
The AMA supports the following general guidelines: I. PREAMBLE The practice of medicine is dynamic and continues to evolve. Additional training may be required to integrate techniques or procedures that are new to the individual physician. The purpose of this document is to provide unifying guidelines for institutions/organizations offering continuing medical education programs and to provide information about training in new procedures for which the physician will request new or expanded privileges. These guidelines are not intended to document competency in a specific procedure. II. INTRODUCTION Continuing advances in the medical sciences and technology have resulted in the development of an array of new technical procedures in patient care, including minimal access surgical procedures. This phenomenon has not only increased the necessity for rapid dissemination of information and instruction regarding the new technologies and procedures but it has triggered a growing number of requests for new or expanded clinical privileges. To ensure safe and effective patient care and to provide assistance to those charged with granting new or expanded clinical privileges, the medical community recognizes the critical need to have appropriate educational standards for training leading to the acquisition of new clinical skills. This training should be accessible, without discrimination, to all physicians in every specialty, who have the appropriate education, training, experience, and documented competence. Moreover, to maintain proficiency in interventional techniques and to enhance technical expertise, an ongoing commitment to continuing medical education is crucial. III. GENERAL GUIDELINES FOR INSTITUTIONS/ORGANIZATIONS The general guidelines, which have been established by the American Medical Association in collaboration with participating medical specialty societies, should be followed by institutions/organizations sponsoring continuing medical education clinical skills training activities regardless of specialty. The skills training activities must be sponsored by an organization accredited by the ACCME or a state medical society, or be approved for Prescribed Credit by the American Academy of Family Physicians for family physicians. Further, any individual skills training activity must demonstrate that it is in substantial compliance with the general guidelines applicable to all clinical skills training activities and the special guidelines, developed by and applicable to clinical skills training activities within a particular medical specialty for physicians in that specialty. The educational activities that meet these guidelines will be listed in a national registry maintained by the AMA in coordination with the appropriate national medical specialty society. The instruction may take place in either (a) a formal learning activity, i.e., course, or (b) a defined clinical preceptorship. Many times both modalities will be used. Ideally, formal learning and a preceptorship will be followed by

observation of the practitioner in his/her own setting. These general guidelines provide practical guidelines to educators in designing clinical skills training activities. They also provide guidance to faculty in evaluating and assessing individual skills acquisition. The process could be useful to credentialing bodies, as one factor in determining whether or not a physician completing a given activity should be granted specific privileges. IIIa. Educational Components. The provider will have a mission of providing procedural learning activities for physicians. The teaching of skills acquisition may be through 1) specific formal courses, 2) a clinical preceptorship, or both. 1. Formal Courses 1a. Learning objectives. There must be a stated set of objectives for each educational activity. These should conform to accepted practice as defined by the specialty/ subspecialty societies. The skills objectives to be taught must be defined as tasks, successful completion of which can be objectively assessed. 1b. Site/Operations. The site of the educational activity must be physically adequate to meet the stated objectives and to provide appropriate facilities for the number of participants enrolled, 1c. Qualifications of faculty. The director of the educational activity and the faculty must be knowledgeable in educational methodology, have the appropriate qualifications, and necessary clinical and/or laboratory expertise to teach the subject matter of the course. These qualifications must meet institutional and specialty/ subspecialty society specifications. There must be an appropriate ratio of clinical faculty to trainees in order to assure that the course objectives are met and to enable documentation of the learner's achievement of these objectives. The director of the educational activity, under the guidance of the sponsoring organization, has the responsibility for setting objectives, curriculum development, faculty and staff appointment, and development of evaluation criteria. The director of the educational activity must disclose directly to the trainees, in advance, any relationships with industry. 1d. Qualifications of trainees. The trainees must have background knowledge, basic skills, and clinical experience relevant to the tasks to be learned. The trainees may be required to provide documentation of the above. If appropriate, the trainees may be pre-tested to demonstrate eligibility. 1e. Curriculum. There must be a written curriculum which should include a list of skills to be acquired, definitions of skill levels and a defined method of progressing from one skill level to the next. Supplemental resource materials (e.g., a bibliography, reprints, videos) must be included or referenced in a syllabus given to all trainees. An educational activity must contain didactic instruction, supported by published or peer-reviewed data in the following areas as they apply to the stated objectives: *R = required information **D = desired information • Patient selection (R) • Indications and contraindications (R) • Historical considerations (D) • Instrumentation (R) • Techniques/adjunctive techniques (R) • Cost considerations/cost effectiveness (R) • Content validity (R) • Management of complications (R) • Documentation methodology (R) • Pre- and post-procedure care (R) • Follow-up policies (R) • Analysis of outcomes (R) • Current research (D) Appropriate components of a skills laboratory may include, but are not limited to: • Reading material and syllabi • Didactic sessions • Inanimate model practice • Animate laboratory instruction and practice • Equipment familiarity • Video, CD ROM, and audio tape instruction/practice • Procedure observation • Simulator/virtual reality models • Interactive computer programs • Self-assessment exercises 1f. Duration of training. The length of the formal educational activity or course should be proportionate to the complexity of the skills to be learned, in order for the trainee to demonstrate the achievement of the defined objectives, and to provide familiarity with the patients and diseases requiring evaluation. 1g. Documentation. The director of the educational activity must provide each trainee with a written summary verifying his/her successful achievement of the defined objectives and specifying the method of measuring that achievement (e.g., passing a post-test). This information may be provided, upon written request, to a credentials committee of a health care organization. 2. Preceptorship in a Clinical Setting 2a. Learning objectives. The clinical preceptorship must have stated objectives. The objectives must include a program outline and a proposed list of tasks and skills to be addressed during the training period. 2b. Site/Operations. The preceptorship site must have a sufficient patient population and facilities to adequately educate the trainee. The preceptorship must be sponsored by an accredited health care organization or a

recognized national medical society with a CME accreditation program. 2c. Qualifications of preceptor. The physician preceptor must be appropriately privileged and have documentable clinical experience in the procedure(s) and/or technique(s) in the particular, field of expertise. The preceptor has the responsibility of setting objectives, developing curriculum, overseeing instruction and practice of skills, demonstrating technique and clinical procedures, and evaluating the trainee under the overall responsibility of the sponsoring organization. The preceptor must disclose directly to the preceptee, in advance, any relationship with industry. The preceptor must have primary responsibility for the care of the patient and is obliged to supervise not only procedures in which the trainee participated but also the appropriate periprocedure care. There must be written evidence of informed consent by the patient, which allows a trainee to be involved in his/her care. As an alternative, evidence of institutional review board research approval must be on file which conforms with the institution's policies and protocols dealing with human research involving patient procedures. 2d. Qualifications of trainee/preceptee. The trainee must have background knowledge, basic skills, and clinical experience relevant to the tasks to be learned. The trainees may be required to provide documentation of the above. In addition, the trainee must have a current and valid license to practice medicine, or meet local requirements for waiver of licensure. The trainee should be able to provide evidence of current liability coverage, hold current clinical privileges in an accredited health care institution, and should have completed an accredited residency training program. Alternatively, the trainee could provide verifiable evidence of equivalent training and/or board certification. 2e. Curriculum. Preceptorship training must be rigorous and based on clinical experiences. Training should include didactic and technical components and may be supplemented with teaching tools at the preceptor's discretion. Most importantly, a preceptorship should include an appropriate number of opportunities for the trainee to both assist and serve as primary operator in the designated procedure and/or technique. 2f. Duration of preceptorship. Training should be proportionate to the complexity of the skills to be taught in order for the preceptee to demonstrate the achievement of the defined objectives, as well as to provide familiarity with the patients and diseases requiring evaluation. 2g. Documentation. The preceptor must document in writing both qualitative and quantitative descriptions of the trainee's experiences. This should include the skills acquired and the number of procedures in which the trainee assisted or served as primary operator. Documentation stating that the procedures were satisfactorily performed must be provided to the preceptee. This information may be provided, upon written request, to a credentials committee of a health care organization. A log of activities kept by the trainee and reviewed by the preceptor and/or credentialing body could assist in the privileging process- Sponsoring institutions must maintain permanent records of preceptees in order to make these available to appropriate authority bodies on request- A certificate of appropriate continuing medical education credit may be provided by the sponsoring organization, if appropriate. 2h. Indemnity. It is the dual responsibility of the preceptor and the trainee to secure appropriate authorization from the host institution and, if necessary, to secure appropriate indemnity coverage. IIIb. Quality Assurance. Health care institutions awarding new or expanded privileges to physicians on the basis of such newly acquired skills must establish a program providing on-going review of the physician's performance, as part of their overall quality assurance program. IIIc. Overall Program Assessment. Every provider of the above described educational activities must regularly evaluate the degree to which its goals are being met as well as evaluate its overall outcomes and be prepared to report these to the appropriate organizations (e.g., AMA, medical specialty societies, and the ACCME). Such evaluations should be systematically documented to ensure that the educational activity is preparing qualified practitioners (e.g., number of procedures performed by each preceptee in the year following the preceptorship, percent complications, etc.). The assessment process must include evaluation of courses and faculty by trainees. IV. SPECIFIC GUIDELINES (to be developed, in collaboration with specialty/ subspecialty societies) (CME Rep. 7, I-95; Reaffirmed and Modified: CME Rep. 2, A-05)

H-230.972, Physician Credentialing and Privileging
The AMA: (1) reaffirms the position that clinical procedures be performed only by physicians with appropriate education, training, experience and demonstrated current competence; (2) supports the position that physicians be assessed on the basis of their education, training, experience and documented competence; (3) in coordination with national medical specialty societies, will pursue the development and application of appropriate guidelines for continuing medical education that is directed toward procedural competence; (4) in collaboration with national medical specialty societies, will organize a national conference to delineate principles for credentialing physicians to perform specific clinical procedures; and (5) in coordination with national medical specialty societies, will develop a process to evaluate educational programs that educate physicians to perform new procedures or procedures which are new for that physician. (CME Rep. 8, I-93; Reaffirmation A-05; Reaffirmed: CLRPD Rep. 1, A-05)

H-255.989, A Program for Exchange Visitor Physicians
(1) It is the AMA's policy to separate the issues involved in the support of alien physicians participating in exchange visitor physician programs for purposes of education, training and/or research followed by return to their native lands from the issues involving U.S. citizens who are graduates of foreign medical schools and alien physician graduates of foreign medical schools who seek permanent residence in the United States. (2) The AMA urges government and private funding of the physician exchange visitor program under the auspices of an appropriate organization that will: consider the range and type of medical education and health care needs of those foreign nations sending exchange visitor physicians; the means to evaluate the level of knowledge and needs of prospective participants in graduate medical education programs; and identify truly outstanding public health, geographic medicine, basic medical science, and clinical training programs to answer the needs of the visitor's native land. (Res. 107, I-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-255.991, Education for Foreign Physicians
After reviewing the past and present status of medical education for physicians of other countries, the AMA adopts the following statement: (1) Medical education in the U.S., consistent with available resources, should recognize and respond to the unique needs of foreign physicians and the environment in which they practice. (2) A first priority for the improvement of medical education in all countries should be directed toward the development of opportunities for medical education at all levels, undergraduate, graduate, remedial, and continuing, within the system of medical education existing in the individual foreign nation or region. (3) U.S. physicians, when resources are available, should be encouraged to contribute to medical education conducted in other countries at the undergraduate, graduate, remedial and continuing levels. (4) The accredited residency program directed toward practice within the U.S. is an educational modality which should be limited to foreign physicians who can be expected to apply what they have learned in the U.S. to the education or practice needs of their own country. (5) Recognition should be afforded graduate programs, tailored to the individual needs of the foreign physicians not involving significant responsibility for the care of patients, and thus obviating the need for foreign physicians, otherwise qualified, to pass the Visa Qualifying Examination. (6) Opportunities for exchange visitor programs of all types pertaining to the improvement of medical education should be compiled and made available to both foreign physicians and U.S. physicians who may have an interest in participating in such programs. (7) Since continuing medical education is of universal importance, efforts to make educational materials available on an even wider basis, such as the foreign language editions of JAMA, deserve commendation. (CME Rep. C, I-85; Modified by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-295.877, Medical Treatment of Prisoners of War and Detainees
Our AMA encourages medical schools to include ethics training on the issue of medical treatment of prisoners of war and detainees. (Sub. Res. 10, A-05)

H-295.879, Improving Sexual History Curriculum in the Medical School
Our AMA (1) encourages all medical schools to train medical students to be able to take a thorough and nonjudgmental sexual history in a manner that is sensitive to the personal attitudes and behaviors of patients in order to decrease anxiety and personal difficulty with sexual aspects of health care; and (2) supports the creation of a national public service announcement that encourages patients to discuss concerns related to sexual health with their physician and reinforces its commitment to helping patients maintain sexual health and well-being. (Res. 314, A-05)

H-295.907, Managed Care and Graduate Medical Education
The American Medical Association will encourage AMA representatives to Residency Review Committees and to the Accreditation Council for Graduate Medical Education to request that these bodies review the impact of the changing health care environment on the feasibility of meeting accreditation standards related to patient volume, number of procedures to be performed, residency program size, and the requirement for the presence of residency programs in other disciplines. (CME Rep. 7, A-97; Modified: CME Rep. 7, A-05)

H-295.918, Strengthening Education in Geriatrics
The AMA supports education in geriatric medicine, with defined curriculum content, goals, and objectives; and encourages enhanced training in residency programs for patient care of the elderly and that the leadership of specialty societies and continuing medical education centers encourage joint educational activities in geriatrics-related topics. (Res. 306, A-95; Reaffirmed: CME Rep. 2, A-05)

H-295.920, Academic Freedom
The AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts by other persons or organizations to interfere with or restrict the availability of this training. (Res. 301, A-95; Reaffirmed: CME Rep. 2, A-05)

H-295.923, Medical Training and Termination of Pregnancy
The AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. (Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14)

H-295.926, Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings
The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications; (2) encourages that medical schools provide faculty development programs that are designated for AMA PRA Category 1 credit; and (3) encourages that teaching continue to be accepted for AMA PRA Category 2 credit. (CME Rep. 3, A-94; Reaffirmed: CME Rep. 2, A-05)

H-295.980, Clinical Training in STD for Medical Students/Physicians in Training
The AMA urges medical schools to provide supervised training in sexually transmitted diseases for all medical students and physicians in training. (Sub. Res. 88, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-300.959, Physician Participation in the AMA Physician's Recognition Award
It is policy that: (1) the AMA, state medical societies, and specialty societies in the AMA House of Delegates publicize and promote physician participation in the AMA Physician's Recognition Award; and (2) that all physicians participate in the AMA Physician's Recognition Award as a visible demonstration of their commitment to continuing medical education. (CME Rep. 1, I-93; Reaffirmed with change in title: CME Rep. 2, A-05)

H-300.969, Uniform Standards for Continuing Medical Education
The AMA (1) will continue its efforts to develop uniform standards for continuing medical education; and (2) will solicit input from all state medical associations, medical licensure boards, and national specialty organizations concerning the development of the most appropriate uniform standards for continuing medical education. (Res. 313, A-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed in lieu of Res. 901, I-05)

H-300.984, Abuses of the Continuing Medical Education System
The AMA urges accredited providers of continuing medical education to accept the responsibility for careful compliance with the "ACCME's Essential Areas and Elements" in order to prevent abuses of the continuing medical education system. (CME Rep. C, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed and Modified: CME Rep. 2, A-05)

H-305.930, Residents' Salaries
Our AMA supports appropriate increases in resident salaries. (Res. 307, A-05)

H-305.942, The Ecology of Medical Education: The Infrastructure for Clinical Education
The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians. (CME Rep. 13, A-97; Modified: CME Rep. 2, I-05)

H-305.948, Direct Loan Consolidation Program
The AMA supports the Individual Education Account/Direct Loan Consolidation Program. (Res. 312, I-95; Reaffirmed: CME Rep. 2, A-05)

H-305.971, Discrimination Against Resident Candidates Based on Graduate Medical Education Medicare Funding
The AMA urges hospitals and residency programs to use qualifications as a basis for filling available positions, and not the status of the Medicare component to graduate medical education funding. (Res. 126, I-88; Modified: Sunset Report, I-98; Modified: CME Rep. 7, A-05)

H-305.990, AMA Foundation Scholars Fund
The AMA urges that all student recipients of monies from the AMA Foundation Scholars Fund be made aware of the source of these funds, and that medical school financial aid offices and medical students be informed of the existence and activities of the AMA and the Medical Student Section. (Res. 134, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified with change in title: CME Rep. 2, A-05)

H-305.991, Repayment of Educational Loans
The AMA (1) believes that it is improper for any physician not to repay his or her educational loans; (2) urges increased efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students; and (3) encourages medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation. (Sub. Res. 47, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-310.924, Fellowship Application Reform
Our AMA supports the concept of a standardized application and selection process for fellowship training positions. (CME Rep. 6, A-05)

H-310.943, Closing of Residency Programs
The AMA: (1) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs;
(2) encourages the ACGME to develop guidelines for the institution to follow in such closings or reductions that provide for adequate notification and out-placement service (such as resource contacts, transfer assistance, and financial assistance);
(3) reminds all institutions involved in educating residents of their contractual responsibilities to the resident;
(4) 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;
(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 undo stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements;
(6) urges institutions that initiate significant reductions in graduate medical education programs (in excess of 20 percent of the trainee complement or in excess of 10 percent of trainees for a given year), or that voluntarily close programs, be requested prior to or at the time of the reduction to file a concise summary of its educational impact with the Accreditation Council for Graduate Medical Education or the relevant Residency Review Committees; and (7) 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. (Sub. Res. 328, A-94; Appended by CME Rep. 11, A-98; Reaffirmed: CME Rep. 7, A-06; Appended: Res. 926, I-12)

H-310.988, Adequate Resident Compensation
The AMA believes that housestaff should receive adequate compensation by their training programs. (Sub. Res. 124, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-310.991, Assistance in Completion of Residency Programs
The AMA supports efforts to assist residents in finding new positions, in the event of reductions in the number of residency positions. (Sub. Res. 106, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-310.993, Resident Participation on Hospital Committees
The AMA encourages hospitals with graduate medical education programs to include residents on hospital executive, fiscal and other committees. (Sub. Res. 37, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed and Modified: CME Rep. 2, A-05)

H-310.994, Curriculum Orientation of Medical Staff Membership in Teaching Programs
The AMA believes that teaching programs in hospitals with residencies throughout the US should incorporate information on the privileges and responsibilities of medical staff membership into their education program's orientation materials. (Res. 142, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-310.995, Anonymity for Resident Inquiries to Residency Review Committees
The AMA supports a detailed procedure to guarantee anonymity of a resident physician who initiates an inquiry by a residency review committee into the conduct of a residency program, to protect residents from reprisals and program directors from unfounded complaints. The procedure includes a mechanism for the resident who elects to forward a complaint to the residency review committee (RRC), outlines options for RRC action; and identifies possible final actions open to the RRC. (CME Rep. C, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-350.963, Minority Physician Recruitment
Our AMA (1) supports national efforts to improve the health services to underserved minority communities; and (2) encourages recruitment of qualified underrepresented minorities to the profession of medicine. (Res. 320, A-05)

H-365.995, Competence in Occupational Medicine of Hospital-Based Physicians Assigned to Occupational Medicine Practice
The AMA recognizes the broad fields encompassed in the practice of occupational medicine and commends those who seek formal training in this specialized field. (Sub. Res. 106, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05)

H-405.965 Essentials for Approval of Examining Boards in Medical Specialties
The AMA endorses the eleventh revision of the Essentials for the Approval of Examining Boards in Medical Specialties (as presented in CME Report 5, A-00). (CME Rep. 5, A-00; Reaffirmed: CME Rep. 2, A-10)

H-405.995, Administration and Supervision of Rehabilitation Units
The AMA believes that (1) third party coverage for the administration and supervision of patient rehabilitation in the office, hospital, and free-standing units should continue to be determined by physician competence based on training and experience, and should not be denied on the basis of specialty certification; and (2) the determination of criteria for qualification in the administration and supervision of rehabilitation units should be based on competence gained by training and

experience, and should not be arbitrarily restricted by specialty designation. (Res. 44, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

H-425.982, Training in the Principles of Population-Based Medicine
The AMA will continue to monitor and support the progress made by medical and public health organizations in championing disease prevention and health promotion; and will continue to develop initiatives to bring schools of medicine and public health back into a closer relationship. (CME Rep. 5, I-95; Reaffirmed: CME Rep. 2, A-05)

H-435.954, Impact of US Medical Liability Premiums on Clinical Medical Education
Our AMA opposes increases in medical liability insurance premiums based solely on preceptor or volunteer faculty status. (CME Rep. 2, I-05)

H-440.969, Meeting Public Health Care Needs Through Health Professions Education
(1) Faculties of programs of health professions education should be responsive to the expectations of the public in regard to the practice of health professions. Faculties should consider the variety of practice circumstances in which new professionals will practice. Faculties should add curriculum segments to ensure that graduates are cognizant of the services that various health care professionals and alternative delivery systems provide. Because of the dominant role of public bodies in setting the standards for practice, courses on health policy are appropriate for health professions education. Additionally, governing boards of programs of education for the health professions, as well as the boards of the institutions in which these programs are frequently located, should ensure that programs respond to changing societal needs. Health professions educators should be involved in the education of the public regarding health matters. Programs of health professions education should continue to provide care to patients regardless of the patient's ability to pay and they should continue to cooperate in programs designed to provide health practitioners in medically underserved areas. (2) Faculty and administrators of health professions education programs should participate in efforts to establish public policy in regard to health professions education. Educators from the health professions should collaborate with health providers and practitioners in efforts to guide the development of public policy on health care and health professions education. (BOT Rep. NN, A-87; Reaffirmed: CSA Rep. 8, A-05)

H-460.989, Animals as Experimental Subjects
The AMA encourages medical school faculty who use animals in the education of students to continue instruction of students on the appropriate use and treatment of animals. (Res. 93, I-83; Reaffirmed: CME Rep. 2, A-05)

H-475.985, Protecting the Integrity of General Surgery as a Specialty
AMA policy is that general surgery is a single specialty, distinct from other surgical specialties and that general surgery should be recognized as such by state regulatory agencies. (Res. 317, A-05)

H-480.988, Allocation of Privileges to Use Health Care Technologies
The AMA (1) affirms the need for the Association and specialty societies to enhance their leadership role in providing guidance on the training, experience and knowledge necessary for the application of specific health care technologies; (2) urges physicians to continue to ensure that, for every patient, technologies will be utilized in the safest and most effective manner by health care professionals; and (3) asserts that licensure of physicians by states must be based on scientific and clinical criteria. (BOT Rep. F, I-88; Reaffirmed: CME Rep. 8, I-93; Reaffirmed: CME Rep. 2, A-05)

HOUSE OF DELEGATES' DIRECTIVES

D-255.989, Expeditious Security Clearance and Visa Processing of Physicians
Our AMA will: (1) lobby the relevant federal agencies to process J-1 and B-1 visa applications and security clearances more expeditiously for IMGs already accepted into residency programs than those in the general pool of visa applicants; (2) lobby the relevant federal agencies to issue J-1 visas to IMGs for the entire duration of their residency program up to a maximum of 7 years; and (3) urge federal agencies and residency programs not to discriminate against any IMGs, particularly those from Pakistan. (Res. 236, A-05)

D-275.973, Essentials for Approval of Examining Boards in Medical Specialties
Our AMA approves the twelfth revision of the Essentials for the Approval of Examining Boards in Medical Specialties. (CME Rep. 1, I-05)

D-275.975, Sharing of Medical Disciplinary Data Among Nations
Our AMA will, in conjunction with the Federation of State Medical Boards, support the efforts of the International Association of Medical Regulatory Authorities in its current efforts toward the exchange of information among medical regulatory authorities worldwide. (Res. 318, A-05)

D-295.954, Teaching and Evaluating Professionalism in Medical Schools
Our AMA will: (1) strongly urge the Liaison Committee on Medical Education (LCME) to promptly create and enforce uniform accreditation standards that require all LCME-accredited medical schools to evaluate professional behavior regularly as part of medical education; (2) strongly urge the LCME to develop standards for professional behavior with outcome assessments at least every eight years, examining teaching and evaluation of the competencies at LCME-accredited medical schools; (3) recognize that evaluation of professionalism is best performed by medical schools and should not be used in evaluation for licensure of graduates of LCME accredited medical schools; (4) continue its efforts to teach and evaluate professionalism during medical education; and (5) actively oppose, by all available means, any attempt by the National Board of Medical Examiners and/or the Federation of State Medical Boards to add separate, fee-based examinations of behaviors of professionalism to the United States Medical Licensing Examinations. (Res. 304, A-05)

D-295.955, Educating Medical Students about the Pharmaceutical Industry
Our AMA will strongly encourage medical schools to include: (1) unbiased curricula concerning the impact of direct-to-consumer marketing practices employed by the pharmaceutical industry as they relate to the physician-patient relationship; and (2) unbiased information in their curricula concerning the pharmaceutical industry regarding (a) the cost of research and development for new medications, (b) the cost of promoting and advertising new medications, (c) the proportion of (a) and (b) in comparison to their overall expenditures, and (d) the basic principles in the decision making process involved in prescribing medications, specifically using evidence based medicine to compare outcomes and cost effectiveness of generic versus proprietary medications of the same class. (Res. 303, A-05)

D-295.957, Medical Student and Resident Physician Education about Pharmaceutical Advertising to Health Professionals
Our AMA will encourage all medical schools and residency programs to educate their students and resident physicians on the possible effects of pharmaceutical advertising and interaction with health professionals and on alternative unbiased sources of information about pharmaceutical products through the AMA curriculum, "What You Should Know About Gifts to Physicians From Industry." (Res. 302, A-04; Reaffirmed: Res. 303, A-05)

D-310.972, Protection Against Delayed Residency Program Closure
Our AMA will: (1) Work closely with the Accreditation Council for Graduate Medical Education to contribute to, review and comment on any new ACGME policies related to residency closures, regardless of cause. (2) Work with the American Board of Medical Specialties to encourage all its member certifying boards to develop a mechanism to accommodate the discontinuities in training which arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training. (3) Work with the ACGME to monitor closing programs, including encouraging programs to immediately notify residents of pending closures and to promptly transfer residents to alternate accredited programs as soon as feasible with the least disruption to training; and strongly encourage programs which accept transferred residents to minimize extensions to total training time. (4) 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. (CME Rep. 7, A-06; Reaffirmed: CME Rep. 4, A-09; Modified: CCB/CLRPD Rep. 2, A-14)

D-310.976, Negative Impact on Surgical and Procedural Education from Revised CMS Interpretive Guidelines for Informed Consent
Our AMA will: (1) cooperate with other interested parties to strongly express its concerns regarding the potentially negative impact on medical education of Sections 482.24(c)(2)(v) and 482.51(b)(2) of the Centers for Medicare and Medicaid Services (CMS) State Operations Manual based on the May 21, 2004 revisions; (2) cooperate with other interested parties to encourage CMS to immediately revise or further clarify Sections 482.24(c)(2)(v) and 482.51(b)(2) of the CMS State Operations Manual and communicate to CMS our desire to assist in the development of new language which both protects patient autonomy and preserves the appropriate flexibility of attending physicians in the teaching environment; and (3) strongly discourage JCAHO from adopting language in its accreditation standards similar to language in Sections 482.24(c)(2)(v) and 482.51(b)(2) of the CMS State Operations Manual based on the May 21, 2004 revision. (Res. 321, A-05)

D-435.979, Impact of US Medical Liability Premiums on Clinical Medical Education
Our AMA will actively investigate the ongoing impact of the medical liability crisis on the availability of full-time and volunteer clinical faculty for undergraduate and graduate medical education. (CME Rep. 2, I-05)