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

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-A-13

Subject: Council on Medical Education Sunset Review of 2003 House Policies

Presented by: Mahendr S. Kochar, MD, Chair

Referred to: Reference Committee C
(A. Patrice Burgess, MD, Chair)

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

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

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

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

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

4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as 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. (BOT Rep. PP, I-84; CLRPD Rep. A, A-89; Reaffirmed:CLRPD Rep. 3 - I-94; Reaffirmed: CLRPD Rep. 2 and 5, I-95; Reaffirmed: Sunset Report, A-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 1, A-02; Modified: CLRPD Rep. 5, A-03; Modified: CCB/CLRPD Rep. 1, A-12)

The Council on Medical Education's recommendations on the disposition of the 2003 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 2003 AND OTHER RELATED HOUSE OF DELEGATES' POLICIES

Policy Number	*Title*	*Recommended Action*
HOUSE OF DELEGATES' POLICIES		
H-30.952	Education Grant Support From the Licensed Beverage Information Council	Rescind; this organization is no longer in existence.
H-35.978	Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital	Retain; still relevant.
H-40.973	Support of the Uniformed Services University of the Health Sciences	Rescind; this is replicated by H-40.970 The Uniformed Services University of the Health Sciences: "The AMA fully supports the continuation of the Uniformed Services University of the Health Sciences as an institution and urges the Executive and Legislative Branches of the United States Government to fulfill their responsibility to our armed forces by fully funding the Uniformed Services University of the Health Sciences."
H-45.984	Proposed Excessive Federal Fees for Aviation Medical Examiners	Rescind; no longer relevant.
H-85.969	Preserving the Vital Role of the Autopsy in Medical Education	Retain; still relevant.
H-95.960	MDs/DOs as Medical Review Officers	Retain in part. Recommendation 3 is too limiting; medical schools, for example, or groups like the AMA, among others, could provide such activities. "The AMA (1) reaffirms its policy that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; ~~(3) urges that MROs obtain continuing medical education through courses offered by appropriate recognized medical specialty societies;~~ and (3~~4~~) vigorously opposes legislation that is inconsistent with these policies."
H-200.992	Designation of Areas of Medical Need	Retain.

H-200.994	Health Workforce	Retain.
H-235.973	Resident Medical Staffs in US Training Hospitals	Rescind; the AMA no longer takes an active role in establishing collective bargaining among resident/fellow physicians in teaching hospitals.
H-255.970	Employment of Non-Certified IMGs	Retain.
H-255.976	Speech Tests for International Medical Graduates	Retain.
H-255.985	Graduates of Foreign Health Professional Schools	Retain.
H-270.974	Acupuncture	Retain.
H-275.959	Cognitive Exams	Retain. Although AMA Policy H-275.978 (18) reflects this concern, that policy is pertinent to medical licensure, not to certification: Our AMA "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."
H-275.998	Physician Competence	Retain.
H-295.881	Clinical Skills Assessment Exam	Rescind; this examination is already in place.
H-295.927	Medical Student Health and Well-Being	Retain.
H-295.931	Pesticide-Herbicide Toxicity Instruction	Rescind; the AMA is against recommending specific curricular mandates.
H-295.933	Medical School Affiliations With VA Medical Centers	Retain.
H-295.934	Physician Training in Health Care Management and Administration	Rescind; reflected in H-295.924 Future Directions for Socioeconomic Education.
H-295.937	Medical Students Infected with Bloodborne Pathogens	Rescind; employers and schools are not allowed to discriminate against students with AIDS or HIV under the Americans with Disabilities Act.
H-295.938	Medical Education Accreditation	Rescind; already reflected in H-310.997, Accreditation of Graduate Medical Education Programs, which states, in part, "(b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and . . . (2) The AMA opposes use of the

		accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice."
H-295.939	OSHA Regulations for Students	Retain
H-295.940	Recruiting Students of Medicine at the Elementary and High School Levels	Retain.
H-295.941	Policies for the Admission of Students from Underserved Areas to Medical Schools	Rescind; reflected in H-350.960 Underrepresented Student Access to US Medical Schools, H-350.978 Minorities in the Health Professions, and H-350.979 Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession.
H-295.948	Health and Disability Insurance for Medical Students	Rescind; already covered in H-295.942 Providing Dental and Vision Insurance to Medical Students and Resident Physicians.
H-295.984	Family Medicine as a Fundamental Subject in Medical Schools	Retain; still relevant.
H-295.992	Medical Student Education Concerning Physician Impairment	Rescind; reflected in H-295.979 Substance Abuse.
H-300.960	Promoting Physician Access to Quality Continuing Medical Education Programs	Rescind. The ACCME is now an independently incorporated organization. The AMA does not have representatives to ACCME; rather, the AMA nominates individuals to be members of its Board of Directors with fiduciary responsibility to the ACCME.
H-300.964	Medical Ethics and Continuing Medical Education	Retain.
H-300.965	The FDA and Continuing Medical Education Supported by Industry	Rescind; recommendation one refers to an event that occurred in 1992. Further, the "guidelines and clear concepts of independence for activities supported by commercial companies" are currently the AMA's Ethical opinions and the ACCME's Standards for Commercial Support which were originally, in their first iteration, guided by the work of the Task Force. For recommendation two, there are no FDA policies on CME, so there is nothing to monitor.
H-300.966	Continuing Medical Education for Physicians in the Hospital Setting	Retain; still relevant.

H-300.968	Protocol for Recognition of State Medical Society Accreditation Programs	Retain in part; recommendation 1 is outdated, but recommendations 2 and 3 are still of concern. "The AMA ~~(1) reaffirms that proposed changes in the Protocol for the Recognition of State Medical Societies to Accredit Intrastate Continuing Medical Education Sponsors, including Guidelines for the Interpretation of the Criteria, be considered matters subject to the review and approval of the ACCME, in accordance with ACCME Bylaws; (2)~~ (1) urges the ACCME Committee for Review and Recognition of State Medical Societies (CRR) to take into consideration the demographic diversity, geographic differences, and varying resources of states when evaluating state medical society accreditation processes; and (~~3~~2) urges the ACCME and CRR to develop reasonable alternate mechanisms (without lowering essential standards) for creating accreditable CME programs in those states and portions of states designated by the federal government as "rural" and whose resources may vary significantly from the norm."
H-300.988	Restoring Integrity to Continuing Medical Education	Retain in part. Under (1): The second definition is used in the AMA-PRA booklet. Under (3): the revised Essentials have undergone multiple changes since the original language shown here. "The AMA (1) supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ~~("Continuing medical education is composed of any education or training which serves to maintain, develop or increase the knowledge, interpretive and reasoning proficiencies, applicable technical skills, professional performance standards or ability for interpersonal relationships that a physician uses to provide the service needed by patients or the public.") and revised ACCME Essentials~~ ("Continuing medical

		education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."); (2) urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities; (3) believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education ~~in the revised ACCME Essentials~~; (4) encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education; and (5) encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the prerogative of defining the continuing education it will accept for credit."
H-305.932	State and Local Advocacy on Medical Student Debt	Retain.

H-310.944	Obstetrics and Gynecology Training in Termination of Pregnancy	Rescind; the specific language is contained in the ACGME Program Requirements for Obstetrics and Gynecology, effective Jan. 1, 2008 (IV.A.2.d): http://acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/220obstetricsandgynecology01012008.pdf
H-310.946	Training Physicians in Non-Traditional Sites	Retain.
H-310.947	Revision of the "General Requirements" of the Essentials of Accredited Residency Programs	Retain.
H-310.952	Housestaff Input During the ACGME Review Process	Retain.
H-310.953	Practice Options and Skills Curriculum for Residents	Retain.
H-310.997	Accreditation of Graduate Medical Education Programs	Retain.
H-330.950	Post-Licensure Assessment as a Condition for Physician Participation in Medicare	Retain.
H-350.964	Racial Ethnic Disparities in Health Care	Rescind; reflected in H-350.969 Medical Education for Members in Underserved Minority Populations: "Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the number of minority medical and premedical students in training…."
H-355.986	Peer Review Implications of Adding Allied Health Practitioners to National Practitioner Data Bank	Rescind; this is covered by H.355.990.
H-355.988	Access to National Practitioner Data Bank	Rescind; covered by H.355.999, Minimum Reporting Requirements to National Practitioner Data Bank: "(4) physicians should not be required to turn over copies of their Data Bank file to anyone not authorized direct access to the Data Bank."
H-355.989	Access to National Practitioner Data Bank "Self-Query" Reports	Retain.
H-355.990	National Practitioner Data Bank	Retain.
H-360.983	Registered Nurse Participation in Epidural Analgesia	Retain.
H-360.997	Nursing Education	Retain; still relevant.
HOUSE OF DELEGATES' DIRECTIVES		
D-200.992	US Physician Shortage	Rescind; directive fulfilled, and this is an ongoing AMA priority (reflected

		in our advocacy for expanded graduate medical education).
D-200.995	Federal Grants to Serve Medically Underserved Areas	Rescind; directive fulfilled.
D-255.990	Nondiscrimination in Residency Selection	Rescind; accomplished.
D-255.992	Opposition to Employment of Non-certified International Medical Graduates	Rescind; the directive has been accomplished, and the rationale behind the directive is reflected in H-255.970, Employment of Non-Certified IMGs.
D-275.966	Eliminating Disparities in Licensure for IMG Physicians	Rescind; reflected in D-275.978 Initial State Licensure: "Our AMA will work with the Federation of State Medical Boards, state medical societies, state medical boards, and state legislatures, to eliminate the additional graduate medical education requirements imposed on IMGs for an unrestricted license, in the earnest hope of implementing AMA Policy H-275.985. (Res. 831, I-04)."
D-275.985	Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation	Rescind. The Council on Medical Education issued two reports at A-04 in response to this resolution. These reports offered updated recommendations that address the concerns of this policy, and, therefore, make this policy outdated (See D-275.981 Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education).
D-275.986	Developing Rational Role for USMLE Step Exams	Rescind; this directive called for a specific study, which has already occurred.
D-295.959	Musculoskeletal Care in Graduate Medical Education	Rescind.
D-295.961	Proposed Consolidation of Liaison Committee on Medical Education Offices	Rescind; the AMA/Association of American Medical Colleges memorandum of understanding confirms the dual structure.
D-300.991	Web-Based System for Registering CME Credits	Rescind; the Council on Medical Education is examining this issue through an A-13 report on retention and availability of CME participation records.
D-300.992	Internet-Based Continuing Medical Education	Rescind; has been accomplished, and these activities will continue without the need for an AMA directive.

D-305.979	State and Local Advocacy on Medical Student Debt	Retain in part. "Our AMA will: (1) support and encourage our state medical societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary care specialties; and (2) urge state medical societies to actively solicit funds (either directly or through their Foundations) for the establishment and expansion of medical student scholarships, and that our AMA develop a set of guidelines and suggestions to assist states in carrying out such initiatives.~~; and (3) study the merits of an annual tuition cap (adjusted for inflation) at public and private medical schools within their states.~~"
D-305.983	Strategies to Combat Mid-year and Retroactive Tuition Increases	Retain in part. Rescind recommendation (3)—which is already reflected in D-305.978—and recommendation (5), as this report already occurred (CME 3-I-04). "Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; ~~(3) identify and disseminate information about model financial aid programs for medical students that have the potential to reduce student debt;~~ and (4) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students.~~; and (5) study the funding of medical education programs, to identify: (a) The status of revenue sources used to support undergraduate and graduate medical education programs, including current constraints on these revenue sources; (b) Strategies to reduce these financial constraints; and (c) Mechanisms to ensure that funding for undergraduate and graduate medical education~~

		~~programs is maintained, so as to reduce the financial burden on medical students and resident physicians.~~
D-305.986	Recognizing Spouse and Dependent Care Expenses in Determining Medical Education Financial Aid	Retain in part. Rescind (3), which has been fulfilled; the AMA is now actively lobbying in Congress on this matter. Rescind (4), as the 2004 Annual meeting has already occurred. "Our AMA will: (1) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid in medical schools; and (2) encourage medical schools to include spouse and dependent health insurance, dependent care, and dependent living expenses as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid.; ~~(3) ask its Council on Medical Education, Section on Medical Schools, and Women Physicians Congress to consider options to carry out the intentions of current House of Delegates' policy on the issue of spouse and dependent health insurance, dependent care, and dependent living expenses; and (4) report back on actions taken on this resolution, and their results, to the House of Delegates at the 2004 Annual Meeting.~~
D-310.999	Clinical Supervision of Resident Physicians by Non-Physicians	Rescind; these issues have been addressed in the duty hours' regulations subsequent to the passing and reaffirmation of the resolution.
D-350.994	Continued Support for Diversity in Medical Education	Rescind; reflected in H-350.969 Medical Education for Members in Underserved Minority Populations: "Our AMA: (1) actively opposes the reduction of resources and opportunities used to increase the

		number of minority medical and premedical students in training….”
D-360.995	Clinical Skills For Labor and Delivery Nurses	Rescind; accomplished.
D-360.998	The Growing Nursing Shortage in the United States	Retain; still relevant.

H-30.952 Education Grant Support From the Licensed Beverage Information Council
The AMA will: (1) not accept funding directly from beer, wine, and distilled spirits companies for the support of any AMA program; (2) continue to accept educational grants from the Licensed Beverage Information Council (LBIC) in order to augment its current educational activities designed to protect the health of the public, provided that the following criteria are followed: (a) the AMA continues to apply the Standards for Commercial Support of Continuing Medical Education of the ACCME, but in the selection of topics and faculty, and in program development, the AMA will be independent of LBIC input; (b) the AMA maintains complete control of the promotion and distribution of the CME materials produced and accepts no accompanying informational materials to its programs without prior review and approval; and (c) all AMA video or printed continuing education programs must contain a message to physicians that explains the AMA policy regarding alcohol abuse and dependence. (BOT Rep. AAA, A-93; Reaffirmed: CLRPD Rep. 5, A-03)

H-35.978 Education Programs Offered to, for or by Allied Health Professionals Associated with a Hospital
The AMA encourages hospital medical staffs to have a process whereby physicians will have input to and provide review of education programs provided by their hospital for the benefit of allied health professionals working in that hospital, for the education of patients served by that hospital, and for outpatient educational programs provided by that hospital. (BOT Rep. B, A-93; Adopts Res. 317, A-92; Reaffirmed: CME Rep. 2, A-03)

H-40.973 Support of the Uniformed Services University of the Health Sciences
The AMA vigorously supports the continuance of the Uniformed Services University of the Health Sciences as vital to the continued strength, morale, and operational readiness of the military services. (Sub. Res. 306, I-93; Reaffirmed: CME Rep. 2, A-03)

H-45.984 Proposed Excessive Federal Fees for Aviation Medical Examiners
The AMA opposes any regulation requiring aviation medical examiners (AMEs) to attend seminars with excessive registration fees and opposes any legislation imposing a fee for serving as an AME for the Federal Aviation Administration. (Res. 209, I-93; Reaffirmed: CME Rep. 2, A-03)

H-85.969 Preserving the Vital Role of the Autopsy in Medical Education
(1) The AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. (2) The AMA will continue to work with other interested groups to increase the rate of autopsy attendance. (CME Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-95.960 MDs/DOs as Medical Review Officers
The AMA (1) reaffirms its policy that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) urges that MROs obtain continuing medical education through courses offered by

appropriate recognized medical specialty societies; and (4) vigorously opposes legislation that is inconsistent with these policies. (Res. 312, A-92; Reaffirmed: CME Rep. 2, A-03)

H-200.992 Designation of Areas of Medical Need
The AMA urges the federal government to: (1) consolidate the federal designation process for identifying areas of medical need; (2) coordinate the federal designation process with state agencies to obviate duplicative activities; and (3) ask for state and local medical society approval of said designated underserved areas. (Res. 24, A-82; Amended: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-200.994 Health Workforce
The AMA endorses the following principle on health manpower: Both physicians and allied health professionals have legal and ethical responsibilities for patient care, even though ultimate responsibility for the individual patient's medical care rests with the physician. To assure quality patient care, the medical profession and allied health professionals should have continuing dialogue on patient care functions that may be delegated to allied health professionals consistent with their education, experience and competency. (BOT Rep. C, I-81; Reaffirmed: Sunset Report, I-98; Modified: CME Rep. 2, I-03)

H-235.973 Resident Medical Staffs in US Training Hospitals
The AMA will work with the AMA Resident and Fellow Section, the AMA Organized Medical Staff Section, state resident and fellow sections, state medical societies, and state and national medical staff services organizations toward the goal of establishing Resident and Fellow Organizations in all U.S. training hospitals. (Res. 835, A-93; Modified: CME Rep. 2, A-03)

H-255.970 Employment of Non-Certified IMGs
Our AMA will: (1) oppose efforts to employ graduates of foreign medical schools who are neither certified by the Educational Commission for Foreign Medical Graduates, nor have met state criteria for full licensure; and (2) encourage states that have difficulty recruiting doctors to underserved areas to explore the expanded use of incentive programs such as the National Health Service Corps or J1 or other visa waiver programs. (Res. 309, A-03)

H-255.976 Speech Tests for International Medical Graduates
The AMA encourages state licensing boards to accept ECFMG certification in satisfaction of requirements for demonstrating English language competence. (CME Rep. B, A-93; Reaffirmed: CME Rep. 2, A-03)

H-255.985 Graduates of Foreign Health Professional Schools
(1) Any United States or alien graduate of a foreign health professional education program must, as a requirement for entry into graduate education and/or practice in the United States, demonstrate entry-level competence equivalent to that required of graduates of United States' programs. Agencies recognized to license or certify health professionals in the United States should have mechanisms to evaluate the entry-level competence of graduates of foreign health professional programs. The level of competence and the means used to assess it should be the same or equivalent to those required of graduates of U.S. accredited programs. (2) All health care facilities, including governmental facilities, should adhere to the same or equivalent licensing and credentialing requirements in their employment practices. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: Res. 320 and Res. 305, A-03; Reaffirmed: CME Rep. 1, I-03)

H-270.974 Acupuncture
It is the policy of the AMA that nonphysician boards should not regulate the clinical practice of medicine. (CME Rep. M, A-93; Modified: CME Rep. 2, A-03)

H-275.959 Cognitive Exams
It is the policy of the AMA to oppose the use of cognitive exams as the major means of evaluating a physician's clinical competence. (Sub. Res. 205, A-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)

H-275.998 Physician Competence
Our AMA urges: (1) The members of the profession of medicine to discover and rehabilitate if possible, or to exclude if necessary, the physicians whose practices are incompetent. (2) All physicians to fulfill their responsibility to the public and to their profession by reporting to the appropriate authority those physicians who, by being impaired, need help, or whose practices are incompetent. (3) The appropriate committees or boards of the medical staffs of hospitals which have the responsibility to do so, to restrict or remove the privileges of physicians whose practices are known to be incompetent, or whose capabilities are impaired, and to restore such physicians to limited or full privileges as appropriate when corrective or rehabilitative measures have been successful. (4) State governments to provide to their state medical licensing boards resources adequate to the proper discharge of their responsibilities and duties in the recognition and maintenance of competent practitioners of medicine. (5) State medical licensing boards to discipline physicians whose practices have been found to be incompetent. (6) State medical licensing boards to report all disciplinary actions promptly to the Federation of State Medical Boards and to the AMA Physician Masterfile. (Failure to do so simply allows the incompetent or impaired physician to migrate to another state, even after disciplinary action has been taken against him, and to continue to practice in a different jurisdiction but with the same hazards to the public.) (CME Rep. G, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-03)

H-295.881 Clinical Skills Assessment Exam
Our American Medical Association opposes the implementation of the Clinical Skills Assessment Exam as part of the United States Medical Licensing Examination by any means, including possible legal action. (Res. 304, A-03)

H-295.927 Medical Student Health and Well-Being
The AMA encourages the Association of American Medical Colleges, Liaison Committee on Medical Education, medical schools, and teaching hospitals to address issues related to the health and well-being of medical students, with particular attention to issues such as HIV infection that may have long-term implications for health, disability and medical practice, and consider the feasibility of financial assistance for students with disabilities. (BOT Rep. 1, I-934; Modified with Title Change: CSA Rep. 4, A-03)

H-295.931 Pesticide-Herbicide Toxicity Instruction
The AMA encourages education in pesticide and herbicide toxicity to be provided at all levels of medical education. (Res. 304, A-93; Reaffirmed: CME Rep. 2, A-03)

H-295.933 Medical School Affiliations With VA Medical Centers
The AMA will work to ensure that the successful relationships between VA academic medical centers and the nation's medical schools are maintained. (Sub. Res. 313, A-93; Modified: CME Rep. 2, A-03)

H-295.934 Physician Training in Health Care Management and Administration
The AMA encourages the development of programs for physician education in health care administration and management.(Sub. Res. 311, A-93; Reaffirmed: CME Rep. 2, A-03)

H-295.937 Medical Students Infected with Bloodborne Pathogens
A medical student who becomes infected with human immunodeficiency virus (HIV) or other bloodborne infectious diseases should not be prevented from completing their course of study and receiving their MD/DO degree based solely on their seropositivity. (Res. 413, I-92; Reaffirmed: CME Rep. 2, A-03; Modified with Title Change: CSA Rep. 4, A-03)

H-295.938 Medical Education Accreditation
The AMA charges its representatives to medical education accrediting bodies to ensure that program accreditation not be used to address specialty distribution of physicians. (Res. 322, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.939 OSHA Regulations for Students
The AMA, working in conjunction with its Medical School Section, encourages all health care related educational institutions to apply existing Occupational Safety and Health Administration Blood Borne Pathogen Standards equally to employees and students. (Sub. Res. 229, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.940 Recruiting Students of Medicine at the Elementary and High School Levels
The AMA will work with state and local medical societies to encourage teachers at primary and secondary schools to alert their students to the potential for professional and personal satisfaction from service to others through a career in medicine. (Res. 319, A-92; Reaffirmed: CME Rep. 2, A-03)

H-295.941 Policies for the Admission of Students from Underserved Areas to Medical Schools
The AMA encourages all U.S. medical schools to develop admissions procedures that will facilitate the admission of students from underserved areas to medical schools, without compromising current admission standards.(Res. 302, A-92; Reaffirmed: CME Rep. 2, A-03)

H-295.948 Health and Disability Insurance for Medical Students
The AMA (1) takes the position that all medical schools and residency programs provide insurance policy options that include a reasonable definition of "sickness" or "disability" that includes HIV infection, and require enrollment in such health and disability insurance plans for all their medical students and residents, and (2) encourages other health professions to provide similar health and disability insurance policies for their students. (BOT Rep. Q, A-91; Amended: BOT Rep. J, I-92; Reaffirmed: CME Rep. 2, A-03)

H-295.984 Family Medicine as a Fundamental Subject in Medical Schools
The AMA recommends that U.S. medical schools include family medicine as a clinical subject. (Res. 14, I-84; Reaffirmed: CMS Rep. L, A-93; Reaffirmed: CME Rep. 2, A-03)

H-295.992 Medical Student Education Concerning Physician Impairment
The AMA (1) supports the teaching of the prevention of physician impairment to medical students and residents; and (2) encourages state medical society physician impairment committees and institutions offering medical education to address student and resident problems with substance abuse. (Sub. Res. 80, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-300.960 Promoting Physician Access to Quality Continuing Medical Education Programs
The AMA will instruct its representatives to the ACCME to advocate: (1) an extensive review and evaluation of the ACCME accreditation review process and criteria, including procedures for training and oversight of accreditation survey team members to assure review quality and continuity; (2) the development of specific documentation criteria which will be expected of accredited institutions and clearly communicate these to the accredited institutions; (3) the emphasis on physician access to quality continuing medical education programming rather than deterring providers with an over-emphasis on unnecessary bureaucratic detail; and (4) that the accreditation process be conducted as a mentoring and constructive process, as well as a quality assurance process. (Res. 313, I-93; Reaffirmed: CME Rep. 2, A-03)

H-300.964 Medical Ethics and Continuing Medical Education
The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision making. (Res. 323, I-92; Reaffirmed: CME Rep. 2, A-03)

H-300.965 The FDA and Continuing Medical Education Supported by Industry
The AMA commends the activities of all parties, including the Food and Drug Administration (FDA), who have worked diligently through the Task Force on CME Provider-Industry Collaboration in CME, to develop guidelines and clear concepts of independence for activities supported by commercial companies. The AMA will continue to monitor the implementation of FDA policies in accredited CME activities. (Sub. Res. 307, I-92; Reaffirmed: CME Rep. 2, A-03)

H-300.966 Continuing Medical Education for Physicians in the Hospital Setting
It is the policy of the AMA that the continuing medical educational programs offered physicians in the hospital setting be the responsibility of the hospital medical staff and directed by the medical staff as defined in the hospital bylaws. (Res. 318, A-92; Reaffirmed: CME Rep. 2, A-03)

H-300.968 Protocol for Recognition of State Medical Society Accreditation Programs
The AMA (1) reaffirms that proposed changes in the Protocol for the Recognition of State Medical Societies to Accredit Intrastate Continuing Medical Education Sponsors, including Guidelines for the Interpretation of the Criteria, be considered matters subject to the review and approval of the ACCME, in accordance with ACCME Bylaws; (2) urges the ACCME Committee for Review and Recognition of State Medical Societies (CRR) to take into consideration the demographic diversity, geographic differences, and varying resources of states when evaluating state medical society accreditation processes; and (3) urges the ACCME and CRR to develop reasonable alternate mechanisms (without lowering essential standards) for creating accreditable CME programs in those states and portions of states designated by the federal government as "rural" and whose resources may vary significantly from the norm. (CME Rep. A, A-92; Reaffirmed: CME Rep. 2, A-03)

H-300.988 Restoring Integrity to Continuing Medical Education
The AMA (1) supports retention of the definitions of continuing medical education in the Physicians' Recognition Award ("Continuing medical education is composed of any education or training which serves to maintain, develop or increase the knowledge, interpretive and reasoning proficiencies, applicable technical skills, professional performance standards or ability for interpersonal relationships that a physician uses to provide the service needed by patients or the public.") and revised ACCME Essentials ("Continuing medical education consists of educational activities which serve to maintain, develop, or increase the knowledge, skills, and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession. The content of CME is that body of knowledge and skills generally recognized and

accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public."); (2) urges members of the medical profession to be attentive to the distinction between continuing medical education and continuing education which is not related directly to their professional activities; (3) believes that accredited sponsors should designate as continuing medical education only those continuing education activities which meet the definition of continuing medical education in the revised ACCME Essentials; (4) encourages the ACCME and state medical associations on the state level to weigh seriously, in considering the sponsor's continued accreditation, instances where an accredited sponsor identifies non-continuing medical education activities as continuing medical education; and (5) encourages state medical boards to accept for credit continuing education which relates directly to the professional activities of physicians, although each state with mandatory continuing medical education for reregistration of license has the prerogative of defining the continuing education it will accept for credit. (CME Rep. A, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-305.932 State and Local Advocacy on Medical Student Debt

Our AMA: (1) opposes the charging of broad and ill-defined student fees by medical schools, such as but not limited to professional fees, encouraging in their place fees that are earmarked for specific and well-defined purposes; (2) encourages medical schools to use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; and (3) encourages medical schools to cooperate with undergraduate institutions to establish collaborative debt counseling for entering first-year medical students. (Res. 847, I-03)

H-310.944 Obstetrics and Gynecology Training in Termination of Pregnancy

The AMA supports the Residency Review Committee for Obstetrics and Gynecology in its current efforts to revise language of the Special Requirements for Obstetrics-Gynecology to provide for specific educational standards for the knowledge and skills associated with the termination of pregnancy that will allow an exclusion for individuals or residency programs with religious/moral objections or legal restrictions, provided that the residents receive a satisfactory knowledge of the principles associated with the termination of pregnancy rather than the actual procedures, and that these exempt residency programs must establish a protocol to allow residents who wish to learn termination of pregnancy procedures to obtain this training in another institution. (Res. 321, I-93; Reaffirmed: CME Rep. 2, A-03)

H-310.946 Training Physicians in Non-Traditional Sites

It is the policy of the AMA to promote and support the training of physicians in non-traditional sites, including nursing homes. (Res. 301, I-93; Reaffirmed: CME Rep. 2, A-03)

H-310.947 Revision of the "General Requirements" of the Essentials of Accredited Residency Programs

The AMA supports the following principles of the ACGME Institutional Requirements: Candidates for residencies must be fully informed of benefits including financial support, vacations, professional leave, parental leave, sick leave, professional liability insurance, hospital and health insurance, disability insurance, and other insurance benefits for the residents and their family and the conditions under which living quarters, meals and laundry or their equivalent are to be provided. Institutions sponsoring graduate medical education must provide access to insurance, where available, to all residents for disabilities resulting from activities that are part of the educational program. Institutions should have a written policy and an educational program regarding physician impairment, including substance abuse. (CME Rep. Q, A-93; Modified: CME Rep. 2, A-03)

H-310.952 Housestaff Input During the ACGME Review Process
The AMA asks its representatives to the Accreditation Council for Graduate Medical Education to support a requirement that site visitors to both residency training programs and institutions conduct interviews with residents, including peer-selected residents, as well as with administrators and faculty. (Res. 314, I-92; Reaffirmed: CME Rep. 2, A-03)

H-310.953 Practice Options and Skills Curriculum for Residents
The AMA will assist medical societies and residency programs in the development of model curricula for resident physicians and those entering practice regarding practice options and management skills, including information on CPT and ICD coding. (Sub. Res. 311, I-92; Reaffirmed: CME Rep. 2, A-03)

H-310.997 Accreditation of Graduate Medical Education Programs
(1) The AMA believes that (a) accreditation and certification programs in graduate medical education should be designed and operated to objectively evaluate the educational quality and content of such programs and to assure a high level of professional training, achievement, and competence; (b) accreditation and certification programs in graduate medical education should not be administered as a means of regulating or restricting the number of physicians entering any specialty or field of medical practice; and (c) qualified physicians who possess the essential prerequisites are entitled to compete for training and subsequently to practice in the specialty or type of practice of their choice upon successful completion of their training. (2) The AMA opposes use of the accreditation and certification process as a means of controlling the number of physicians in any specialty or field of medical practice. (Res. 14, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

H-330.950 Post-Licensure Assessment as a Condition for Physician Participation in Medicare
The AMA opposes proposals for periodic post-licensure assessment as a condition for physician participation in the Medicare program or other health-related entitlement program. (Res. 231, I-93; Reaffirmed: BOT Rep. 28, A-03)

H-350.964 Racial Ethnic Disparities in Health Care
Our AMA opposes the elimination of programs or mechanisms designed to increase the number of minority physicians.(BOT Rep. 4, A-03)

H-355.986 Peer Review Implications of Adding Allied Health Practitioners to National Practitioner Data Bank
The AMA will continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank. (Res. 817, A-93; Reaffirmed: BOT Rep. 28, A-03)

H-355.988 Access to National Practitioner Data Bank
The AMA will inform its members that entities who are authorized to query the National Practitioner Data Bank should not request physicians to self-query on the entities' behalf. (Res. 804, A-93; Reaffirmed: BOT Rep. 28, A-03)

H-355.989 Access to National Practitioner Data Bank "Self-Query" Reports
(1) The AMA again requests a written opinion from the Health Resources and Services Administration's Bureau of Health Professions and/or the HHS Office of the Inspector General, as to the confidentiality of National Practitioner Data Bank (NPDB) information that is received directly or indirectly from the NPDB. (2) The AMA recommends that physicians who are compelled to release information received from the NPDB to entities not authorized to access the NPDB require that such entity provide them with written documentation that: information

disclosed to the entity will be protected from further disclosure under the relevant state peer review immunity statute(s); that the requirements that the physician self-query the NPDB and disclose the information to the entity is in compliance with the intent and protections of the Health Care Quality Improvement Act of 1986; that the information will be used only for and maintained only for those purposes, such as quality assurance activities, that are protected under the relevant state peer review immunity statute(s); and that the entity will protect the confidentiality of the information to the fullest extent permitted by both state law and the Health Care Quality Improvement Act of 1986. (3) The AMA will provide model language until such legislation is enacted that physicians can use to protect confidentiality when they release information received from the NPDB to entities not authorized to access the NPDB. The AMA urges state and county medical societies to develop a mechanism physicians can use to report problems they encounter with these entities. (BOT Rep. L, I-92; Reaffirmed: BOT Rep. 28, A-03)

H-355.990 National Practitioner Data Bank

(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB). (2) The AMA requests that the Health Resources and Services Administration (a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner's self-query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than $30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (e) allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB's first year of operation to the AMA by July 1992. (3) The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991. (BOT Rep. QQ, A-92; Reaffirmed: BOT Rep. 28, A-03)

H-360.983 Registered Nurse Participation in Epidural Analgesia

Our AMA, consistent with the American Society of Anesthesiologists position statement adopts the following statement on the administration of epidural analgesia: In order to provide optimum patient care, it is essential that registered nurses participate in the management of analgesic modalities. A registered nurse--qualified by education, experience and credentials--who follows a patient-specific protocol written by a qualified physician should be allowed to adjust and discontinue catheter infusions. (Res. 530, A-03)

H-360.997 Nursing Education

The AMA (1) supports all levels of nursing education, including baccalaureate, diploma, associate degree and practical nursing in order that individuals may be able to choose from a number of alternatives, each of which legitimately fulfills the purpose of meeting the health care needs of the nation; (2) affirms that there is no substitute for bedside teaching and practical learning in any education program for nurses; and (3) recommends strong support of multiple levels of nursing education in order to make available career ladders in the various levels of nursing education without dead-ends or repetitions of education. (Res. 4, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CME Rep. 2, A-03)

D-200.992 US Physician Shortage
Our AMA will draft a report outlining policy options to address the US physician supply. (Res. 807, I-03)

D-200.995 Federal Grants to Serve Medically Underserved Areas
Our AMA will encourage physicians interested in the availability of federal grants available for service in medically underserved areas, to review the information on the US Department of Health and Human Services web site at www.hhs.gov/grantsnet. (CMS Rep. 2, I-03)

D-255.990 Nondiscrimination in Residency Selection
Policy H-255.983 will be communicated to the Accreditation Council for Graduate Medical Education and to all residency program directors. (Sub. Res. 314, A-04)

D-255.992 Opposition to Employment of Non-certified International Medical Graduates
Our AMA, in conjunction with the California Medical Association, will recommend to the California legislature and the California Hispanic Healthcare Association, other solutions to the California physician shortage including (1) maximizing their use of existing programs such as the National Health Service Corps and the J-1 visa waiver program, and (2) recruiting Spanish-speaking physicians who have recently retired by assisting them with state licensing and liability concerns. Our AMA, in conjunction with state medical societies, will respond to attempts by states to employ non-certified physicians for patient care by recommending solutions to those states such as (1) maximizing their use of existing programs such as the National Health Service Corps and the J-1 visa waiver program, and (2) recruiting physicians who have recently retired by assisting them with state licensing and liability concerns. (Res. 320, A-03)

D-275.966 Eliminating Disparities in Licensure for IMG Physicians
Our AMA will advocate and assist the state medical societies to seek legislative action eliminating any disparity in the years of graduate medical education training required for full and unrestricted licensure between IMG and LCME graduates. (Res. 327, A-08; Reaffirmation A-10)

D-275.985 Clinical Skills Assessment Exam and College of Osteopathic Medicine Licensing Exam-Physical Exam Implementation
Our AMA will: (1) study mechanisms for providing feedback to medical students on their performance on the proposed United States Medical Licensing Exam Clinical Skills Assessment Examination (CSAE) and College of Osteopathic Medicine Licensing Exam-Physical Exam (COMLEX-PE) including but not limited to written narrative feedback, and access to video recording of the exam for possible review with their medical school and communicate these findings to the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME); (2) encourage medical schools to develop mechanisms to assist medical students to meet financial obligations associated with the requirements for participation in the CSAE and COMLEX-PE; (3) encourage medical schools to avoid linking passage of the CSAE and COMLEX-PE to graduation requirements for at least the first five years after the implementation of the proposed exam; (4) in conjunction with the National Resident Matching Program, the American Osteopathic Association, the Accreditation Council for Graduate Medical Education, and other interested organizations, study the potential impact of the CSAE and COMLEX-PE on undergraduate and graduate medical education and report back at the 2004 Annual Meeting; (5) strongly encourage the NBME and NBOME to develop policies to ensure adequate capacity for registration and administration of the proposed CSAE and COMLEX-PE in order to accommodate all students testing for the initial time as well ensuring students failing the exam can retest within 60 days; (6) monitor in an ongoing fashion, the proposed implementation of the CSAE and COMLEX-PE and its impact on the medical education continuum; and (7) involve

all interested groups at the AMA in any AMA deliberations regarding the CSAE as well as utilization of this or a similar test for recertification purposes, to ensure that the perspectives of all physicians are reflected. (Res. 324, A-03)

D-275.986 Developing Rational Role for USMLE Step Exams
Our American Medical Association, with appropriate partners, will study what role, if any, scaled and scored national, standardized examinations like the USMLE Steps I and II should have in evaluation of applicants for residency, and propose appropriate changes to the examination(s) in order to serve that role. (Res. 303, A-03)

D-295.959 Musculoskeletal Care in Graduate Medical Education
Our AMA will: (1) strongly urge our medical schools to formally reevaluate the musculoskeletal curriculum; (2) strongly urge our medical schools to make changes that ensure medical school students have the appropriate education and training in musculoskeletal care, and make competence in basic musculoskeletal principles a graduation requirement for medical school; and . (3) encourage its representatives to the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, and the various Residency Review Committees to promote higher standards in basic competence in musculoskeletal care in accreditation standards. (Res. 310, A-03)

D-295.961 Proposed Consolidation of Liaison Committee on Medical Education Offices
Our AMA will continue to support the current dual Secretariat structure for the management of the Liaison Committee on Medical Education. (CME Rpt. 7, A-03)

D-300.991 Web-Based System for Registering CME Credits
(1) Our American Medical Association, through the Division of Continuing Physician Professional Development, will perform a new feasibility analysis to determine if reinitiating the CME Credit Tracker project is possible. (2) The Council on Medical Education will monitor the progress of the analysis and facilitate constructive dialogue with all interested stakeholders. (CME Rep. 5, A-03)

D-300.992 Internet-Based Continuing Medical Education
(1) Our AMA will express its appreciation to the Accreditation Council for Continuing Medical Education and to the AMA PRA program for anticipating issues associated with Internet-based CME, and for developing clear policy to guide physicians and accredited CME providers in this area. (2) The Council on Medical Education will remain closely involved with the evaluation processes of the current AMA PRA Internet CME Pilot Project and develop appropriate new language for the certification of AMA PRA category 1 credit for self-directed, self-initiated, Internet-based CME. (3) The AMA PRA program will continue to monitor the area of Internet-based CME and report back to the House of Delegates as major changes occur. (CME Rep. 4, A-03)

D-305.979 State and Local Advocacy on Medical Student Debt
Our AMA will: (1) support and encourage our state medical societies to support further expansion of state loan repayment programs, and in particular expansion of those programs to cover physicians in non-primary care specialties; (2) urge state medical societies to actively solicit funds (either directly or through their Foundations) for the establishment and expansion of medical student scholarships, and that our AMA develop a set of guidelines and suggestions to assist states in carrying out such initiatives; and (3) study the merits of an annual tuition cap (adjusted for inflation) at public and private medical schools within their states. (Res. 847, I-03)

D-305.983 Strategies to Combat Mid-year and Retroactive Tuition Increases
Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; (3) identify and disseminate information about model financial aid programs for medical students that have the potential to reduce student debt; (4) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students; and (5) study the funding of medical education programs, to identify: (a) The status of revenue sources used to support undergraduate and graduate medical education programs, including current constraints on these revenue sources; (b) Strategies to reduce these financial constraints; and (c) Mechanisms to ensure that funding for undergraduate and graduate medical education programs is maintained, so as to reduce the financial burden on medical students and resident physicians. (CME Rep. 3, I-03)

D-305.986 Recognizing Spouse and Dependent Care Expenses in Determining Medical Education Financial Aid
Our AMA will: (1) work with the Liaison Committee on Medical Education to require, as part of the accreditation standards for medical schools, that dependent health insurance, dependent care, and dependent living expenses be included both as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid in medical schools; (2) encourage medical schools to include spouse and dependent health insurance, dependent care, and dependent living expenses as part of the "cost of attendance" and as an educational expense for the purposes of student budgets and financial aid; (3) ask its Council on Medical Education, Section on Medical Schools, and Women Physicians Congress to consider options to carry out the intentions of current House of Delegates' policy on the issue of spouse and dependent health insurance, dependent care, and dependent living expenses; and (4) report back on actions taken on this resolution, and their results, to the House of Delegates at the 2004 Annual Meeting. (Res. 301, A-03)

D-310.999 Clinical Supervision of Resident Physicians by Non-Physicians
In light of the concerns of the AMA Resident Physician Section and the adoption of amended Principle 16, the ACGME be asked to clarify ACGME Institutional and Program Requirements regarding the responsibility for resident supervision. (CME Rep. 3, A-99; Reaffirmed: Res. 322, A-03)

D-350.994 Continued Support for Diversity in Medical Education
Our AMA will publicly state and reaffirm its strong opposition to the reduction of opportunities used to increase the number of minority and premedical students in training. (Res. 325, A-03)

D-360.995 Clinical Skills For Labor and Delivery Nurses
Our AMA will encourage the National League of Nursing Accrediting Commission and the Commission on Collegiate Nursing Education to emphasize education and certificate training programs that assure the necessary clinical skills for labor and delivery nurses to be able to adjust the rate of epidural infusion for patients. (Res. 530; A-03)

D-360.998 The Growing Nursing Shortage in the United States
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. (CMS Rep. 7, A-01; Modified: Res. 708, A-03)