At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110, AMA Policy Database). 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 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

• In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
• Using the areas of expertise of the AMA Councils as a guide, it is determined which policies should be reviewed by each Council.
• For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
• The Speakers assign each policy sunset report for consideration by the appropriate Reference Committee.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

The Council on Medical Education’s recommendations on the disposition of the 1999 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.
### APPENDIX - RECOMMENDED ACTIONS ON 1999 HOUSE OF DELEGATES' POLICIES

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Title</th>
<th>Recommended Action and Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-30.983</td>
<td>Medical Education on Alcoholism and Other Chemical Dependencies</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-35.989</td>
<td>Physician Assistants</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-200.957</td>
<td>Proper Notification and Education regarding Healthcare Professional Shortage Areas by Medicare Carrier</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-230.959</td>
<td>Ultrasound and Biopsy of the Thyroid</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-230.989</td>
<td>Patient Protection and Clinical Privileges</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-255.974</td>
<td>Preservation of Opportunities for US Graduates and International Medical Graduates Already Legally Present in the US</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-275.935</td>
<td>Licensure of IMGs</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-295.887</td>
<td>Clinical Skills Assessment in Medical School</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-295.888</td>
<td>Progress in Medical Education: the Medical School Admission Process</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-295.889</td>
<td>Color Blindness</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>Code</td>
<td>Policy Description</td>
<td>Recommendation</td>
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<tr>
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</tr>
<tr>
<td>H-295.890</td>
<td>Medical Education and Training in Women’s Health</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-295.891</td>
<td>Governance of the National Resident Matching Program</td>
<td>Rescind. NRMP governance has been changed several times over the past ten years but not in accordance with AMA policy.</td>
</tr>
<tr>
<td>H-295.906</td>
<td>Cardiopulmonary Resuscitation and Basic Life Support Training for First-Year Medical Students</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-295.919</td>
<td>Advanced Cardiac Life Support Training</td>
<td>Retain in part. #1 and #2 are still relevant. Recommend deletion of #3 – data has been collected.</td>
</tr>
<tr>
<td>H-310.929</td>
<td>Principles for Graduate Medical Education</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-310.930</td>
<td>Attending Physician Supervision of Night-Float Rotations</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-310.932</td>
<td>Annual Contracts for Continuing Residents</td>
<td>Retain. Although the ACGME Institutional Requirements address this issue, the policy is still relevant.</td>
</tr>
<tr>
<td>H-310.933</td>
<td>Implementing Independent Housestaff Organizations</td>
<td>Rescind. The ACGME has created robust requirements for grievance procedures and AMA efforts to directly assist local housestaff to create organizations have been redirected to other issues.</td>
</tr>
<tr>
<td>H-350.968</td>
<td>Progress in Medical Education: the Medical School Admission Process – Change title to “Medical School Faculty Diversity”</td>
<td>Retain. The policy is still relevant but has the same title as H-295.888.</td>
</tr>
<tr>
<td>H-350.969</td>
<td>Medical Education for Members in Underserved Minority Populations</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>Directive Code</td>
<td>Description</td>
<td>Action</td>
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<td>---------------------------------------------</td>
</tr>
<tr>
<td>H-350.970</td>
<td>Diversity in Medical Education</td>
<td>Retain. Still relevant but really should be a directive rather than a policy.</td>
</tr>
<tr>
<td>H-480.969</td>
<td>The Promotion of Quality Telemedicine</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td><strong>DIRECTIVES TO TAKE ACTION</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D-200.998</td>
<td>Physician Workforce Planning and Physician Re-Training</td>
<td>Retain in part. Retain #1 – Directive continues to be relevant. Rescind #2 - The AMA Initiative to Transform Medical Education is addressing workforce and physician re-training issues.</td>
</tr>
<tr>
<td>D-225.999</td>
<td>The Emerging Use of Hospitalists: Implications for Medical Education</td>
<td>Retain. The directive is still relevant. AMA will continue to monitor the educational implications of the “hospitalist” movement.</td>
</tr>
<tr>
<td>D-230.998</td>
<td>Provisional Credentialing of Newly Trained Physicians for MCO Networks</td>
<td>Rescind. The directive continues to be relevant but is superseded by H-180.956, D-180.993, D-230.996, H-310.921, and D-310.965.</td>
</tr>
<tr>
<td>D-295.953</td>
<td>Medical School Accreditation</td>
<td>Rescind. The situation that stimulated this directive no longer exists – the actions were taken.</td>
</tr>
<tr>
<td>D-295.987</td>
<td>Medical Schools and Colleges not Accredited by the Liaison Committee on Medical Education or the American Osteopathic Association</td>
<td>Rescind. The AMA has a web site that addresses this information.</td>
</tr>
<tr>
<td>Directive</td>
<td>Description</td>
<td>Action</td>
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<tr>
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</tr>
<tr>
<td>D-295.988</td>
<td>Clinical Skills Assessment During Medical School</td>
<td>Retain. LCME is working on benchmarks for compliance with this and other standards.</td>
</tr>
<tr>
<td>D-295.989</td>
<td>An Update on the Environment for Medical Students</td>
<td>Rescind. The LCME has a new standard in the Medical Education Learning Environment with a detailed annotation of expectations.</td>
</tr>
<tr>
<td>D-295.990</td>
<td>Nutritional and Dietetic Education for Medical Students</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-295.991</td>
<td>Medical Students Functioning as Phlebotomists</td>
<td>Rescind. The directive has been done.</td>
</tr>
<tr>
<td>D-295.992</td>
<td>Development of Courses to Prepare Medical Students and Residents for the Political, Legal and Socioeconomic Aspects of Practice and Physician Advocacy</td>
<td>Retain. The AMA continues to be integrally involved in the development of Introduction to the Practice of Medicine (IPM) courses for resident physicians which cover the areas indicated in this directive. This is also a goal of ITME.</td>
</tr>
<tr>
<td>D-295.994</td>
<td>Standardization of MCAT Expiration Period</td>
<td>Rescind. The AAMC has a policy that MCAT expiration dates are a responsibility of the faculty of individual schools.</td>
</tr>
<tr>
<td>D-295.996</td>
<td>Update on Development of Branch Campuses of International Medical Schools</td>
<td>Retain in part. Rescind #s 1, 2 and 3. The situation described in the directive did not occur. Retain #4 – directive continues to be relevant.</td>
</tr>
<tr>
<td>D-305.996</td>
<td>Coding for Services involving Teaching Activity</td>
<td>Retain in part. Retain #1. The directive continues to be relevant. Rescind #2 – CMS no longer has the PATH audit program in effect.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Action</td>
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</tr>
<tr>
<td>D-305.997</td>
<td>Training of Physicians under Managed Care</td>
<td>Retain in part. Retain #1 - the directive is still relevant. Rescind #2 and #3 – directives have been completed.</td>
</tr>
<tr>
<td>D-310.996</td>
<td>Compliance with Resident Work Hour Requirements</td>
<td>Rescind. Multiple other actions have superseded this directive.</td>
</tr>
<tr>
<td>D-310.997</td>
<td>Compliance with National Resident Matching Program Requirements by Residency Program Directors</td>
<td>Rescind. The National Resident Matching Program monitors this closely and provides reports. Also, AMA has appointees serving on the NRMP Board.</td>
</tr>
<tr>
<td>D-310.998</td>
<td>Medical Education Financing</td>
<td>Rescind. Directives have been completed.</td>
</tr>
<tr>
<td>D-383.998</td>
<td>Impact of the NLRP Ruling in the Boston Medical Center Case</td>
<td>Rescind. Many intervening events and actions.</td>
</tr>
<tr>
<td>D-383.999</td>
<td>Alternative to the Development of a Collective Bargaining Unit for Resident Physicians</td>
<td>Rescind. The ACGME has created robust requirements for grievance procedures and AMA efforts to directly assist local housestaff to create organizations have been redirected to other issues.</td>
</tr>
<tr>
<td>D-480.999</td>
<td>State Authority and Flexibility in Medical Licensure for Telemedicine</td>
<td>Retain in part. Rescind #1 – superseded by H-120.949. Retain #2 – directive continues to be relevant.</td>
</tr>
</tbody>
</table>
APPENDIX

HOUSE OF DELEGATES’ POLICIES

H-30.983 Medical Education on Alcoholism and Other Chemical Dependencies
The AMA supports (1) taking a leadership role in educating or causing changes in physician education for exposure to early identification, treatment and prevention of alcoholism and other chemical dependencies; and (2) public education efforts in coordination with other interested groups on an ongoing basis. (Res. 67, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 10, A-99)

H-35.989 Physician Assistants
(1) The AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.
(2) A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.
(3) The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician
assistants that a particular physician may supervise or a group of physicians may employ.
(4) While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.
(5) The AMA opposes legislation or proposed regulations authorizing physician assistants to make independent medical judgments as to the drug of choice for an individual patient.
(6) In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.

H-200.957 Proper Notification and Education Regarding Healthcare Professional Shortage Areas by Medicare Carrier
Our AMA shall educate member physicians regarding Medicare Part B carriers' responsibility to notify all physicians that if they practice in a Healthcare Professional Shortage Area, they are eligible for incentive payments under Centers for Medicare & Medicaid Services guidelines, and they may be eligible to file amended claims under the incentive payment program retroactively for up to twelve months. (Res. 103, I-99)

H-230.959 Ultrasound and Biopsy of the Thyroid
Our AMA adopts the position that only appropriately trained and credentialed physicians (M.D. and D.O.) and appropriately trained and certified ultrasound technologists perform ultrasound examinations of the thyroid and that only appropriately trained and credentialed physicians evaluate and interpret ultrasound examinations and perform ultrasound-guided biopsies of the thyroid. (Sub. Res. 818, I-99)

H-230.989 Patient Protection and Clinical Privileges
Concerning the granting of staff and clinical privileges in hospitals and other health care facilities, the AMA believes: (1) the best interests of patients should be the predominant consideration; (2) the accordance and delineation of privileges should be determined on an individual basis, commensurate with an applicant's education, training, experience, and demonstrated current competence. In implementing these criteria, each facility should formulate and apply reasonable, nondiscriminatory standards for the evaluation of an applicant's credentials, free of anti-competitive intent or purpose; (3) differences among health care practitioners in their clinical privileges are acceptable to the extent that each has a scientific basis. However, the same standards of performance should be applied to limited practitioners who offer the kinds of services that can be performed by limited licensed health care practitioners or physicians; and (4) health care facilities that grant privileges to limited licensed practitioners should provide that patients admitted by limited licensed practitioners undergo a prompt medical evaluation by a qualified physician; that patients admitted for inpatient care have a history taken and a
comprehensive physical examination performed by a physician who has such privileges; and that each patient's general medical condition is the responsibility of a qualified physician member of the medical staff. (Sub. Res. 36, A-84; Reaffirmed: CME Rep. 8, I-93; Reaffirmed: Res. 802, I-99)

H-255.974 Preservation of Opportunities for US Graduates and International Medical Graduates Already Legally Present in the US
In the event of reductions in the resident workforce, the AMA will advocate for a mechanism of resident selection which promotes the maintenance of resident physician training opportunities for all qualified graduates of United States Liaison Committee on Medical Education and American Osteopathic Association accredited institutions; and the AMA adopts the position that it will be an advocate for IMGs already legally present in this country. (Res. 324, A-97; Reaffirmed: CME Rep. 10, A-99)

H-275.935 Licensure of IMGs
Our AMA asks the Federation of State Medical Boards to ask all the state licensing boards to adopt a uniform standard governing the allowed number of administrations of the licensure examinations. (Res. 314, A-99)

H-295.887 Clinical Skills Assessment During Medical School
Our AMA encourages medical schools that do not already do so to implement valid and reliable methods to evaluate medical students’ clinical skills. (CMS Rep. 7, I-99)

H-295.888 Progress in Medical Education: the Medical School Admission Process
Our AMA encourages: (1) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (2) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (3) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges. (CME Rep. 8, I-99)

H-295.889 Color Blindness
Our AMA will encourage medical schools to be aware of students with color blindness and its effect on their medical studies. (Sub. Res, 303, A-99)

H-295.890 Medical Education and Training in Women's Health
Our AMA: (1) encourages the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women’s health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women’s health throughout the basic science and clinical phases of the curriculum; (2) does not support the designation of women’s health as a distinct new specialty; (3) that each specialty should define objectives for residency training in women’s health, based
on the nature of practice and the characteristics of the patient population served;
(4) that surveys of undergraduate and graduate medical education, conducted by the AMA and
other groups, should periodically collect data on the inclusion of women’s health in medical
school and residency training;
(5) encourages the development of a curriculum inventory and database in women’s health for
use by medical schools and residency programs;
(6) encourages physicians to include continuing education in women’s health/gender based
biology as part of their continuing professional development; and
(7) encourages its representatives to the Liaison Committee on Medical Education, the
Accreditation Council for Graduate Medical Education, and the various Residency Review
Committees to promote attention to women’s health in accreditation standards.
(Jt. Rep. CME and CSA, A-99)

H-295.891 Governance of the National Resident Matching Program
Our AMA will encourage the National Resident Matching Program to structure its governance
board so as to include designated seats for direct representation of residency directors and the
medical school deans of students.  (Res. 302, A-99)

H-295.906 Cardiopulmonary Resuscitation and Basic Life Support Training for First-Year
Medical Students
Our AMA encourages training of cardiopulmonary resuscitation and basic life support to first-
year medical students, preferably during the first term.  (Res. 305, A-97; Reaffirmed:
CME Rep. 3, I-99

H-295.919 Advanced Cardiac Life Support Training
Our AMA: (1) strongly supports the teaching of advanced cardiac life support and basic life
support beginning in medical school and continuing during residency training; and (2) encourages
medical schools to include the following areas related to airway management as part of the
required curriculum: (a) airway anatomy and function; (b) basic life support and advanced cardiac
life support, and (c) airway management and intubation in the unconscious patient; and (3) will
monitor the teaching in medical schools related to airway management in the unconscious patient.

H-310.929 Principles for Graduate Medical Education
Our AMA urges the Accreditation Council for Graduate Medical Education to incorporate these
principles in the revised "Institutional Requirements" of the Essentials of Accredited Residencies
of Graduate Medical Education, if they are not already present.

(1) PURPOSE OF GRADUATE MEDICAL EDUCATION. There must be objectives for
residency education in each specialty that promote the development of the knowledge, skills,
attitudes, and behavior necessary to become a competent practitioner in a recognized medical
specialty.

(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.
Accreditation requirements should relate to the stated purpose of a residency program and to the
knowledge, skills, attitudes, and behaviors that a resident physician should have on completing
residency education.
(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS. Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following: the initial authorization of programs, the appointment of program directors, compliance with the Essentials for Accredited Residencies in Graduate Medical Education, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) COMPENSATION OF RESIDENT PHYSICIANS. All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) LENGTH OF TRAINING. The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program.
Requirements. The time required for an individual resident physician’s education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) PROVISION OF FORMAL EDUCATIONAL EXPERIENCES. Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) INNOVATION OF GRADUATE MEDICAL EDUCATION. The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.
(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician’s specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution. (CME Rep. 9, A-99)

**H-310.930 Attending Physician Supervision of Night-Float Rotations**
Our AMA supports hospitals and residency programs including those utilizing a night-float system, continuing to assure that there is rapid access to appropriately qualified attending physicians for trainee supervision and the provision of the best quality of patient care. (Res. 320, A-99)

**H-310.932 Annual Contracts for Continuing Residents**
Our AMA urges the ACGME to require resident training programs to provide their residents with notice of non-renewal of contracts no later than four months prior to the end of their contract. (Sub. Res. 310, A-99)

**H-310.933 Implementing Independent Housestaff Organizations**
The AMA will develop and implement a nationwide program offering supporting materials as well as telephone and on-site assistance to groups of residents seeking to form independent housestaff organizations disavowing actions that could adversely affect the well being of patients. (Res. 322, A-98; Reaffirmed: Res. 914, A-99)

**H-350.968 Progress in Medical Education: the Medical School Admission Process**
Our AMA encourages increased recruitment and retention of faculty members from underrepresented minority groups as part of efforts to increase the number of individuals from underrepresented minority groups entering and graduating from US medical schools. (CME Rep. 8, I-99)

**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; (2) uses its influence in states and local communities to increase the representation of minority group members in medical education, as long as domestic health care disparities exist between minority populations and the greater population at-large; and (3) supports the need for an increase in the participation of underrepresented minorities as investigators, trainees, reviewers, and subjects in peer review biomedical research at all levels. (Sub. Res. 316, A-99; Reaffirmed CME Rep. 8, I-99)

**H-350.970 Diversity in Medical Education**
Our AMA will: (1) request that the AMA Foundation seek ways of supporting innovative programs that strengthen pre-medical and pre-college preparation for minority students; (2) support and work in partnership with local state and specialty medical societies and other relevant groups to provide education on and promote programs aimed at increasing the number of minority medical school admissions; applicants who are admitted; and (3) encourage medical schools to consider the likelihood of service to underserved populations as a medical school admissions criterion. (BOT Rep. 15, A-99)
H-480.969 The Promotion of Quality Telemedicine

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

(a) application to situations where there is a telemedical transmission of individual patient data from the patient's state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board's state;
(b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations ("curbside consultations") that are provided without expectation of compensation;
(c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
(d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as "educational tools"); Policy 410.987 (which identifies practice parameters as "strategies for patient management that are designed to assist physicians in clinical decision making," and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99)

DIRECTIVES TO TAKE ACTION

D-200.998 Physician Workforce Planning and Physician Re-Training

Our AMA will (1) consider physician retraining during all its deliberations on physician workforce planning; and (2) assess the extent of physician retraining needs by appropriately surveying all U.S. residency programs, to identify the number of physicians undergoing specialty retraining, and to report its findings to the House of Delegates at A-2000.

(Res. 324, A-99)

D-225.999 The Emerging Use of Hospitalists: Implications for Medical Education

(1) Our AMA, through its Council on Medical Education and Council on Medical Service, will collect data on the following areas: (a) the emergence of educational opportunities for hospitalist
physicians at the residency level, including the curriculum of hospitalist tracks within residency training programs; (b) the availability and content of continuing medical education opportunities for hospitalist physicians; (c) the policies of hospitals and managed care organizations related to the maintenance of hospital privileges for generalist physicians who do not typically care for inpatients; and (d) the quality and costs of care associated with hospitalist practice.

(2) Our Council on Medical Education and Council on Medical Service will monitor the evolution of hospitalist programs, with the goal of identifying successful models.

(3) Our AMA will encourage dissemination of information about the education implications of the emergence of hospitalism to medical students, resident physicians, and practicing physicians. (CME Rep. 2, A-99)

D-230.998 Provisional Credentialing of Newly Trained Physicians for MCO Networks

Our AMA will work with the National Committee for Quality Assurance (NCQA) to establish guidelines for the provisional credentialing of newly trained physicians and relocation of established physicians for Managed Care Organization (MCO) networks within their accreditation standard for physician credentialing. (Res. 307, I-99)

D-230.999 Facilitating Entry into Practice

Our AMA: (1) will encourage residency program directors to send letters, on request, stating the resident’s satisfactory progress in the residency to date and an expected graduation date, that will help assist a resident to meet credentialing requirements; (2) will work through the American Board of Medical Specialties and the Federation of State Medical Boards to encourage timely notification of board certification results and medical licensure status; and (3) as a matter of urgency, will work with all relevant entities to establish mechanisms for provisional credentialing of newly trained physicians and to facilitate the relocation of established physicians. (Sub. Res. 301, I-99)

D-275.997 Clinical Skills Assessment (CSA)

Our AMA: (1) will encourage the Educational Commission for Foreign Medical Graduates (ECFMG) to develop additional test sites for CSAs with a re-evaluation of the cost of this examination to minimize the financial and logistical barriers imposed on the applicants; (2) will support continued development and implementation of a clinical skills examination component into the United States Medical Licensure Examination (USMLE); (3) will requests the National Board of Medical Examiners (NBME) to provide updates as to the review and validation of their CSA; and (4) through its representation on the NBME will ask that the CSA not be implemented until the fiscal and geographic burdens are minimized. (CME Rep. 5, A-99)

D-295.953 Medical School Accreditation

Our AMA will:
(1) disseminate an informational packet to state medical societies for use in communicating the meaning and importance of accreditation to various constituencies;
(2) prepare and disseminate an analysis of the legal options to promote the accreditation of branch campuses of non-US medical schools, including the development of model state legislation;
(3) provide this information to delegates and alternate delegates; and
(4) explore partnering with the Association of American Medical Colleges, which has the standardized application, to ensure that everyone making an application gets the informational packet on the importance of accreditation through those means. (BOT Action in response to referred for decision Res. 318, A-99)
D-295.987 Medical Schools and Colleges not accredited by the liaison committee on medical education or The American Osteopathic Association
Our AMA will work with the Association of American Medical Colleges and other organizations to develop educational materials for pre-medical students and advisors in US undergraduate schools about the difficulties their students may face, including obtaining a residency position, after graduation from medical schools and colleges not accredited by the Liaison Committee on Medical Education or the American Osteopathic Association. (Sub. Res. 304, I-99)

D-295.988 Clinical Skills Assessment During Medical School
Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should "develop a system of assessment" to assure that students have acquired and can demonstrate core clinical skills. (CME Rep. 7, I-99)

D-295.989 An Update on the Environment for Medical Students
Our AMA will: (1) ask its representatives to the Liaison Committee on Medical Education (LCME) to request that the LCME collect and make available data on medical schools’ progress in defining the standards of conduct in the teacher-learner relationship and on the policies that are implemented to address violations of these standards; (2) encourage medical schools to obtain student opinions about the quality of student services, for example, through review of the responses to the Association of American Medical Colleges Medical School Graduation Questionnaire, and to correct areas that are identified by students as deficiencies; and (3) disseminate this report to medical schools through its Section on Medical Schools and Medical Student Section, to encourage awareness of the importance of issues related to the medical student. (CME Rep. 2, I-99)

D-295.990 Nutritional and Dietetic Education for Medical Students
Our AMA will: (1) offer to assist the American Society for Clinical Nutrition in meeting its commitment to ensure that medical schools have appropriate faculty role models to teach clinical nutrition; and (2) identify and disseminate to medical schools new instructional initiatives that heighten the relevance of clinical nutrition content to medical practice. (CME Rep. 1, I-99)

D-295.991 Medical Students Functioning as Phlebotomists
Our AMA will communicate its concerns to the hospital community and other appropriate entities on the need to achieve balance between providing adequate phlebotomy training for medical students and ensuring that medical students are not over-utilized for this purpose by the routine substitution of medical students for phlebotomists or IV technicians. (Sub. Res. 5, I-99)

D-295.992 Development of Courses to Prepare Medical Students and Residents for the Political, Legal and Socioeconomic Aspects of Practice and Physician Advocacy
Our AMA will assist local and state medical societies to develop education programs on the political, legal, and socioeconomic aspects of medical practice and physician advocacy, to be offered to medical students and physicians in residency training throughout the country to supplement their clinical education and prepare them for practice. (Res. 322, A-99)
D-295.993  Grievance and Appeals Process for Physicians-in-Training
Our AMA and its appropriate specialty sections will study physicians-in-training contracts and
develop model language for the grievance and appeals process in physicians-in-training contracts.
(Res. 301, A-99)

D-295.994  Standardization of MCAT Expiration Period
Our AMA will work with the Association of American Medical Colleges to develop a policy
regarding a standardized expiration period for Medical College Aptitude Test scores, allowing for
modification of the expiration period if the exam format changes significantly.  (Res. 307, A-99)

D-295.996  Update on Development of Branch Campuses of International Medical Schools
It is recommended that the AMA take the following actions in lieu of adoption of
Resolution 316 (I-98):
(1) Monitor the status of the branch campus of Ross Medical School, and continue to provide
information and other appropriate support to the Wyoming Medical Society.
(2) Work with state and county medical societies where new branch campuses of non-U.S.
medical schools are being proposed, to provide information to policy makers, the public, potential
students, and other interested parties about the role of LCME-accreditation in ensuring
educational quality.
(3) Continue to support the WWAMI program as a way to provide access to quality medical
education for students who are residents of Wyoming, Alaska, Idaho, and Montana, and as a way
to increase the number of physicians who will practice in those states.
(4) Join with the Association of American Medical Colleges in continuing to support the process
of voluntary accreditation of medical education programs.  (BOT Rep. 25, A-99)

D-305.996  Coding for Services Involving Teaching Activity
Our AMA will continue: (1) its efforts to develop the next generation of CPT coding, with
attention to the coding needs of teaching physicians; and (2) to work with the Association of
American Medical Colleges and CMS to clarify and minimize the documentation requirements
for teaching physicians.  (BOT Rep. 7, A-99)

D-305.997  Training of Physicians Under Managed Care
Our AMA will: (1) monitor ongoing legislative initiatives and support specific language that
would preserve the opportunities for medical students and resident physicians to participate in the
care of patients under the supervision of the responsible attending staff; (2) monitor and promote
mutually beneficial private initiatives between managed care organizations and educational
entities that would preserve the opportunities for medical students and resident physicians to
participate in the care of patients under the supervision of the responsible attending staff; and (3)
ask the Liaison Committee on Medical Education to survey those medical schools and academic
health centers with managed care contracts for the presence of exclusion provisions that curtail
the education of medical students and resident physicians.  (CME Rep. 4, A-99)
D-310.996 Compliance with Resident Work Hour Requirements
(1) ACGME will be asked to collect and report annually the number and variety of violations of duty-hour requirements identified by each Residency Review Committee (2) Our AMA will study the impact of prolonged work hours, including moonlighting, on resident physician performance and well-being. (CME Rep. 5, I-99)

D-310.997 Compliance with National Resident Matching Program Requirements by Residency Program Directors
(1) Our AMA will distribute to medical students (via the Medical Student Section) copies of the forthcoming National Resident Matching Program (NRMP) brochure summarizing NRMP policies and procedures.
(2) Our AMA will distribute to medical students (via the Medical Student Section) information about the process for reporting violations of NRMP policies and procedures.
(3) Our AMA will continue to monitor the issue and report back to the House of Delegates on progress in reducing the number of violations, either through the annual report on medical education or, if warranted, in a separate report.
(4) Organizations of program directors be included in future discussions of violations of NRMP policies and procedures.

D-310.998 Medical Education Financing
Our AMA: (1) in consultation with the Medical Student Section, will prepare a comprehensive report on medical education financing to examine methods of decreasing the cost of medical education to students, specifically including tuition reduction, tuition caps, increasing grants, and subsidized loans, investigating legislative and school-based aid options; (2) will develop strategies to ensure adequate funding for medical schools; and (3) will develop reports on (a) reducing the cost of medical education to students and (b) medical school financing, and that these reports be presented to the House of Delegates at I-2000. (Res. 308, I-99)

D-383.998 Impact of the NLRB Ruling in the Boston Medical Center Case
Our AMA will prepare a report on the potential impact of the National Labor Relations Board ruling on physicians-in-training, including issues related to education, GME funding, resident finances and the formation of housestaff organizations. (Res. 309, I-99)

D-383.999 Alternative to the Development of a Collective Bargaining Unit for Resident Physicians
(1) Our AMA support and reinforce mechanisms within the Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME) to address and resolve resident issues at the program and institutional levels. (2) Policy H-310.933, calling for the AMA to assist in the development of independent (professional) housestaff organizations, be reaffirmed. Further, the AMA should encourage the ACGME immediately to convene a task force drawn from its sponsoring organizations to develop a model for a professional housestaff organization that can serve as a vehicle to address and resolve conflicts between housestaff and sponsoring institutions. (3) Our AMA immediately develop and implement mechanisms to provide direct assistance to individual residents and groups of residents with work-related concerns, such as the creation of a housestaff support unit coordinated by the AMA, and identify the costs of implementation of such a plan. Such a unit should be structured to confidentially address resident issues and conflicts at the program or institution levels and diminish the need for intervention by the ACGME. (Res. 914, A-99)
D-480.999 State Authority and Flexibility in Medical Licensure for Telemedicine

Our AMA will: (1) develop a policy regarding the practice of medicine as it relates to the prescribing of prescription-only pharmaceuticals or other therapies via the Internet; and (2) continue its opposition to a single national federalized system of medical licensure.

(CME Rep. 7, A-99)