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 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 Council 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 2001 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 2001 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-40.994</td>
<td>Military Physicians in Graduate Medical Education Programs</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-40.995</td>
<td>Graduate Medical Education in the Military</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-140.977</td>
<td>Residency Training in Medical-Legal Aspects of End-of-Life Care</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-150.995</td>
<td>Basic Courses in Nutrition</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-250.996</td>
<td>Enhancing Young Physicians’ Effectiveness in International Health</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-255.997</td>
<td>Fifth Pathway</td>
<td>Rescind. As of 2009, the Fifth Pathway no longer provides eligibility to sit for Step 3 of the USMLE. Therefore, there are no new entrants to Fifth Pathway programs. The principle underlying this policy is valid, but the Fifth Pathway no longer is relevant.</td>
</tr>
<tr>
<td>H-255.998</td>
<td>Foreign Medical Graduates</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-260.978</td>
<td>Salary Equity for Laboratory Personnel</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-275.934</td>
<td>Alternatives to the Federation of State Medical Boards Recommendations on Licensure</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-275.993</td>
<td>Examinations for Medical Licensure</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-295.943</td>
<td>Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical Students</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-300.946</td>
<td>Inappropriate Use of Social Security Numbers in CME Accreditation</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-300.973</td>
<td>Promoting Quality Assurance, Peer Review, and Continuing Medical Education</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-300.974</td>
<td>Unification of Continuing Education Credits</td>
<td>Rescind #1. The activities have been accomplished. Retain #2. The policy is still relevant.</td>
</tr>
<tr>
<td>Policy Number</td>
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<td>Recommended Action And Rationale</td>
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</tr>
<tr>
<td>H-300.975</td>
<td>Fraudulent/Legitimate Continuing Medical Education Activities</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-300.992</td>
<td>National Accreditation of AMA as Provider of Continuing Medical Education</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-305.940</td>
<td>Tax Exemption for Federal Medical Profession Scholarships</td>
<td>Rescind. The policy no longer is relevant. According to the IRS, qualified scholarship and fellowship grants are treated as tax-free. Also, there is no need to include in gross income amount received for services that are required by the National Health Service Corps Program or the Armed Forces Health Professions Scholarship (IRS.gov, Topic 421).</td>
</tr>
<tr>
<td>H-305.955</td>
<td>Cost of Medical School and Educational Loan Interest</td>
<td>Rescind in favor of Policy H-305.962 and H-305.997 which are more general. Deductions are available for interest paid on a qualified student loan if conditions set by the IRS are met.</td>
</tr>
<tr>
<td>H-305.962</td>
<td>Taxation of Federal Student Aid</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-305.997</td>
<td>Income Tax Exemption for Medical Student Loans and Scholarships</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-310.957</td>
<td>Resident Working Conditions Reform Update</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-310.959</td>
<td>In-Service Training Examinations – Final Report</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-310.960</td>
<td>Resident Education in Laboratory Utilization</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-310.961</td>
<td>Residency/Fellowship Working Conditions and Supervision</td>
<td>Rescind. This report is vague and two more detailed reports already exist: H-310.979, Resident Physician Working Hours and Supervision (reaffirmed CME Report 2, A-08), and H-310.963, Resident/Fellowship Working Hours and Supervision (reaffirmed CME Report 2, I-00).</td>
</tr>
<tr>
<td>H-355.979</td>
<td>National Practitioner Data Bank</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-355.983</td>
<td>Reporting of Malpractice Information in the National Practitioner Data Bank</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-355.985</td>
<td>National Practitioner Data Bank</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-355.992</td>
<td>Reporting Impaired Physicians to the National Practitioner Data Bank</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>Policy/Directive Number</td>
<td>Title</td>
<td>Recommended Action And Rationale</td>
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<tr>
<td>H-355.993</td>
<td>National Practitioner Data Bank</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-410.986</td>
<td>Resident Involvement in Practice Parameters</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>H-450.950</td>
<td>Revise National Practitioner Data Bank Criteria</td>
<td>Retain. The policy is still relevant.</td>
</tr>
<tr>
<td>D-180.995</td>
<td>Physician Privileges Application – Timely Review by Managed Care</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-255.994</td>
<td>Report on the Fifth Pathway</td>
<td>Rescind. With the ending of the Fifth Pathway there are no developing programs or prospective students and the AMA no longer monitors adherence to its requirements.</td>
</tr>
<tr>
<td>D-275.990</td>
<td>Implementation of NBME Clinical Skills Assessment Exam</td>
<td>Rescind. The Step 2 Clinical Skills Examination has been implemented.</td>
</tr>
<tr>
<td>D-275.992</td>
<td>Unified Medical License Application</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-275.993</td>
<td>Reporting of Resident Physicians</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-275.994</td>
<td>Facilitating Credentialing for State Licensure</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-295.977</td>
<td>Implementation of NBME Clinical Skills Assessment Exam</td>
<td>Rescind. This has been accomplished. LCME standard ED-27 states that “A medical education program must include ongoing assessment activities that ensure that medical students have acquired and can demonstrate on direct observation the core clinical skills, behaviors, and attitudes that have been specified in the program’s educational objectives.”</td>
</tr>
<tr>
<td>D-295.978</td>
<td>Mid-Year and Retroactive Medical School Tuition Increases</td>
<td>Rescind. The activities specified in this directive have been accomplished. The report mandated in this directive resulted in the following policy: Medical School Tuition Increases (H-305.934), which states that “Our American Medical Association opposes the imposition of mid-year and retroactive tuition increases at both public and private schools.”</td>
</tr>
<tr>
<td>D-295.979</td>
<td>Education for the Prevention of Professional Liability Lawsuits</td>
<td>Rescind. Our AMA has undertaken many activities related to this directive. For example, the Introduction to the Practice of Medicine program for residents includes modules on “Malpractice” and “Patient Safety.”</td>
</tr>
<tr>
<td>Directive Number</td>
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<tr>
<td>D-295.980</td>
<td>Web-Based AMCAS Application</td>
<td>Rescind. The activities in this directive have been accomplished.</td>
</tr>
<tr>
<td>D-295.982</td>
<td>Model Pain Management Program for Medical School Curricula</td>
<td>Retain. The directive is relevant and data are collected periodically.</td>
</tr>
<tr>
<td>D-300.994</td>
<td>Reduced Continuing Medical Education (CME) Fees for Retired Physicians</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-300.995</td>
<td>Reducing Burdens of CME Accreditation and Documentation</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-300.996</td>
<td>Model Pain Management Program for Medical School Curricula</td>
<td>Retain, with change in title to read, “Voluntary Continuing Education for Physicians in Pain Management.” The directive is still relevant and the change in title is suggested to reflect the content of the directive.</td>
</tr>
<tr>
<td>D-300.997</td>
<td>Use of Medical Education Numbers in Continuing Medical Education</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-300.998</td>
<td>Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-305.990</td>
<td>Impact of Health System Changes on Medical Education</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-305.991</td>
<td>Tax Deductibility for Student Loan Interest</td>
<td>Rescind. Legislation and regulations related to student loan interest tax deductibility have changed.</td>
</tr>
<tr>
<td>D-310.990</td>
<td>Resident/Fellow Work and Learning Environment</td>
<td>Rescind. This directive has been completed. More recent reports were adopted by the House of Delegates on resident work hours and patient safety, and existing policies include: H-310.926 Resident/Fellow Work and Learning Environment (Resolution 322, A-03), H-310.928 Resident/Fellow Work and Learning Environment (Resolution 322, A-03), and H-310.929 Principles for Graduate Medical Education CME Report 14, A-09). The Council on Medical Education is submitting an updated report on these issues at this meeting (Report 7).</td>
</tr>
<tr>
<td>D-310.991</td>
<td>Intern and Resident Working Hours</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-310.992</td>
<td>Limits on Training Opportunities for J-1 Residents</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>Directive Number</td>
<td>Title</td>
<td>Recommended Action And Rationale</td>
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<tr>
<td>D-310.993</td>
<td>Fair Process for Physicians-In-Training</td>
<td>Rescind. The activity specified in this directive has been accomplished.</td>
</tr>
<tr>
<td>D-355.997</td>
<td>Reporting of Resident Physicians</td>
<td>Retain. The directive is still relevant.</td>
</tr>
<tr>
<td>D-360.997</td>
<td>The Effect of Nursing Shortage on Medical Education</td>
<td>Rescind. This directive has been completed and replaced by more current AMA policies including: H-360.984, Nursing Shortage (Resolution 313, A-02), H-360.982, Leadership for Patient Safety: Reducing the Hospital Registered Nurse Shortage at the Bedside (BOT Report 27, A-08), H-360.995, Nursing Education and the Supply of Nursing Personnel in the United States (reaffirmed CLRPD Report 2, A-07), H-360.993, Local Physician-Nurse Committee to Find Solution for Bedside Nursing Shortage (CMS Report 7, A-01), and H-360.999, Nursing Education (reaffirmed CME Report 2, A-08).</td>
</tr>
</tbody>
</table>
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H-40.994  Military Physicians in Graduate Medical Education Programs
Our AMA opposes any arbitrary attempt to limit the percentage of resident physicians in military graduate education or training programs. (Res. 71, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00)

H-40.995  Graduate Medical Education in the Military
Our AMA: (1) strongly supports and endorses the graduate medical education programs of the military services and recognizes the potential benefit to the military services of recruitment, retention and readiness programs; and (2) is gravely concerned that closures of military medical centers and subsequent reduction of graduate medical education programs conducted therein will not only impede the health care mission of the Department of Defense, but also harm the health care of the nation by increasing the drain on trained specialists available to the civilian sector. (Sub. Res. 1, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

H-140.977  Residency Training in Medical-Legal Aspects of End-of-Life Care
Our AMA encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment. (Res. 66, A-90; Reaffirmed: Sunset Report, I-00)

H-150.995  Basic Courses in Nutrition

H-250.996  Enhancing Young Physicians' Effectiveness in International Health
It is the policy of the AMA to work with national medical specialty societies and other organizations in preparing materials which guide young physicians in the development of skills necessary for effectively promoting the health of poor populations both in the United States and abroad. (Res. 407, I-91; Reaffirmed: Sunset Report, I-01)

H-255.997  Fifth Pathway
Our AMA supports the principle that any existing or proposed alternative programs conducted by U.S. medical schools to facilitate entry of U.S. citizens studying in foreign medical schools into U.S. programs should assure that those who complete such programs are reasonably comparable to the school's regularly enrolled and graduated students. (CME Rep. D, A-81; Reaffirmed: CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

H-255.998  Foreign Medical Graduates
Our AMA supports the following principles, based on recommendations of the Ad Hoc Committee on Foreign Medical Graduates (FMGs): Our AMA supports the practice of U.S. teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals

H-260.978 Salary Equity for Laboratory Personnel
It is the policy of the AMA to promote adequate compensation for medical technologists, cytotechnologists and other medical laboratory personnel and to promote increased funding for their educational programs. (Sub. Res. 39, A-91; Reaffirmed: Sunset Report, I-01)

H-275.934 Alternatives to the Federation of State Medical Boards Recommendations on Licensure
Our AMA adopts the following principles:

(1) Ideally, all medical students should successfully complete Steps 1 and 2 of the United States Medical Licensing Examination (USMLE) or Parts 1 and 2 of the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) prior to entry into residency training. At a minimum, individuals entering residency training must have successfully completed Step 1 of the USMLE or Part 1 of COMLEX. There should be provision made for students who have not completed Step 2 of the USMLE or Part 2 of the COMLEX to do so during the first year of residency training.

(2) All applicants for full and unrestricted licensure, whether graduates of U.S. medical schools or international medical graduates, must have completed one year of accredited graduate medical education (GME) in the U.S., have passed all licensing examinations (USMLE or COMLEX), and must be certified by their residency program director as ready to advance to the next year of GME and to obtain a full and unrestricted license to practice medicine. The candidate for licensure should have had education that provided exposure to general medical content.

(3) There should be a training permit/educational license for all resident physicians who do not yet have a full and unrestricted license to practice medicine. To be eligible for an initial training permit/educational license, the resident must have completed Step 1 of the USMLE or Part 1 of COMLEX.

(4) Residency program directors shall report only those actions to state medical licensing boards that are reported for all licensed physicians.

(5) Residency program directors should receive training to ensure that they understand the process for taking disciplinary action against resident physicians, and are aware of procedures for dismissal of residents and for due process. This requirement for residency program directors should be enforced through Accreditation Council for Graduate Medical Education accreditation requirements.

(6) There should be no reporting of actions against medical students to state medical licensing boards.

(7) Medical schools are responsible for identifying and remediating and/or disciplining medical student unprofessional behavior, problems with substance abuse, and other behavioral problems, as well as gaps in student knowledge and skills.

(8) The Dean’s Letter of Evaluation should be strengthened and standardized, to serve as a better source of information to residency programs about applicants. (CME Rep. 8, A-99; Reaffirmed: CME Rep. 4, I-01)
H-275.993 Examinations for Medical Licensure
Our AMA affirms its recommendation that medical school faculties continue to exercise the
responsibilities inherent in their positions for the evaluation of students and residents, respectively.

H-295.943 Issues Regarding Patient and/or Donor Transports by Resident Physicians and Medical
Students
Our AMA (1) urges medical schools not to require medical students to participate in the air or
ground transport of patients or organs during required clinical rotations; and (2) encourages all
teaching institutions where medical students or resident physicians participate (compulsorily or
voluntarily) in the air or ground transport of patients or organs (a) to notify respective students and
residents of all program requirements related to transports; (b) to include accident, disability, and
life insurance as part of an available package for participating medical students and resident
physicians, and to provide such insurance where participation is mandatory; (c) to include in the
educational curriculum formal training on general and safety issues pertaining to emergency
transport before students or residents participate in such activity; and (d) to adhere to the
Association of Air Medical Services (AAMS) Minimum Quality Standards and Safety Guidelines

H-300.946 Inappropriate Use of Social Security Numbers in CME Accreditation
Our AMA opposes the use of Social Security numbers as: (1) a requirement to obtain continuing
medical education credit and strongly encourage the use of the AMA Medical Education number
for such educational activities; and (2) file identifiers by providers of continuing medical
education, certification boards and similar entities, suggesting instead the use of the AMA Medical
Education number where such a unique identifier is required and applicable.(Res. 306, A-00;
Appended Res. 301, A-01)

H-300.973 Promoting Quality Assurance, Peer Review, and Continuing Medical Education
Our AMA: (1) reaffirms that it is the professional responsibility of every physician to participate in
voluntary quality assurance, peer review, and continuing medical education activities; (2) to
encourage hospitals and other organizations in which quality assurance, peer review, and
continuing medical education activities are conducted to provide recognition to physicians who
participate voluntarily; (3) to increase its efforts to make physicians aware that participation in the
voluntary quality assurance and peer review functions of their hospital medical staffs and other
organizations provides credit toward the AMA's Physicians' Recognition Award; and (4) to
continue to study additional incentives for physicians to participate in voluntary quality assurance,
peer review, and continuing medical education activities. (BOT Rep. SS, I-91; Reaffirmed: Sunset
Report, I-01)

H-300.974 Unification of Continuing Education Credits
Our AMA (1) forwards this report to the American Academy of Family Physicians, the American
College of Obstetricians and Gynecologists, the California Medical Association, and other
interested parties for their deliberation, with a request for specific action, if needed, to endorse
these standards: (a) a common definition of continuing medical education; (b) use of merged
terminology for similar CME activities; and (c) recognition of only those CME programs which
meet the ACCME "Guidelines for Commercial Support of CME," and follow the AMA Ethical
Opinion on "Gifts to Physicians"; and (2) accepts AAFP prescribed credit hours and ACOG
cognate credit hours for formal learning, as equivalent to AMA PRA category 1.
(CME Rep. C, I-91; Reaffirmed: Sunset Report, I-01)
H-300.975 Fraudulent/Legitimate Continuing Medical Education Activities
Our AMA supports the development and publication of guidelines to assist physicians in identifying continuing medical education of high quality, responsive to their needs, and supports the promulgation of ethical principles regarding the responsibilities of physicians to participate in continuing medical education programs which they claim for continuing medical education recognition, credit or other purposes. (Sub. Res. 64, A-91; Reaffirmed: Sunset Report, I-01)

H-300.992 National Accreditation of AMA as Provider of Continuing Medical Education
Our AMA assigns to the CME the responsibility to be the unit of the AMA to become accredited for continuing medical education. (BOT Rep. NN, A-81; CLRPD Rep. F, I-91; Modified: Sunset Report, I-01)

H-305.940 Tax Exemption for Federal Medical Profession Scholarships
Our AMA plans to work with the American Association of Medical Colleges in support of federal legislation that will assure that the direct medical school expense portion of the National Health Service Corps Scholarship program, the Armed Forces Health Professions Scholarship program and all other federally funded health profession scholarships is not taxable. (Res. 225, I-97; Reaffirmation A-01)

H-305.955 Cost of Medical School and Educational Loan Interest
Our AMA encourages legislation to restore the tax deductibility of student loan interest. (Res. 305, I-92; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01)

H-305.962 Taxation of Federal Student Aid
Our AMA opposes legislation that would make medical school scholarships or fellowships subject to federal income or social security taxes (FICA). (Res. 210, I-91; Reaffirmed: Sunset Report, I-01)

H-305.997 Income Tax Exemption for Medical Student Loans and Scholarships
The AMA supports continued efforts to obtain exemption from income tax on amounts received under medical scholarship or loan programs. (Res. 65, I-76; Reaffirmed: Sunset Report, I-98; Reaffirmation A-01)

H-310.957 Resident Working Conditions Reform Update
(1) Our AMA supports the following new language pertaining to resident work hours and environment for the "General Requirements" of the "Essentials of Accredited Residencies in Graduate Medical Education": Each residency program must establish formal policies governing resident duty hours and working environment that are optimal for both resident education and the care of patients. (a) Special requirements relating to duty hours and on-call schedules shall be based on an educational rationale and patient need, including continuity of care. (b) The educational goals of the program and learning objectives of residents must not be compromised by excessive reliance on residents to fulfill institutional service obligations. Duty hours, however, must reflect the fact that responsibilities for continuing patient care are not automatically discharged at specific times. Programs must ensure that residents are provided backup support when patient care responsibilities are especially difficult or prolonged. (c) Resident duty hours and on-call schedules must not be excessive. The structuring of duty hours and on-call schedules must focus on the needs of the patient, continuity of care, and the educational needs of the resident. Duty hours must be consistent with the General and Special Requirements that apply to each program. Detailed structuring of resident service is an integral part of the approval process and therefore close adherence to the General and Special Requirements is essential to program accreditation. (2) Our AMA supports the following proposed revision of the "Special Requirements" for surgery: It is
desirable that residents' work schedule be designed so that on the average, excluding exceptional patient care needs, residents have at least one day out of seven free of routine responsibilities and be on-call in the hospital no more often than every third night. The ratio of hours worked and on-call time will vary, particularly at the senior levels, and therefore necessitates flexibility. (BOT Rep. YY, I-91; Reaffirmed: Sunset Report, I-01)

H-310.959 In-Service Training Examinations - Final Report
It is the policy of the AMA (1) to encourage entities responsible for in-service examinations and the ACGME to recognize that in-service training examinations should not be used in decisions concerning acceptance, denial, advancement, or retention in residency or fellowship training positions; should not be used by outside regulatory agencies for the purpose of assessing resident knowledge or the quality of training programs; and should not be used as a pretest to sit for specialty boards; (2) to encourage residency program directors to use the results of in-training examinations to counsel residents and as the basis for developing appropriate programs of remediation and also for the purpose of educational program evaluation; and (3) to urge that evaluation of residents for promotion or retention be based on valid and reliable measures of knowledge, skills, and behaviors, applied sequentially over time. In-training examinations should be administered under appropriate testing conditions. Residents should be relieved of on-call duty the night prior to and during the administration of the examination. The results, if used at all, should not be the sole factor in evaluation of residents. (CME Rep. A, I-91; Reaffirmed: Sunset Report, I-01)

H-310.960 Resident Education in Laboratory Utilization
Our AMA endorses the concept of practicing physicians devoting time with medical students and resident physicians for chart reviews focusing on appropriate test ordering in patient care. (Res. 84, A-91; Reaffirmed: Sunset Report, I-01)

H-310.961 Residency/Fellowship Working Conditions and Supervision
Our AMA will continue to work closely with the parties involved in the accreditation of graduate medical education programs to reaffirm the AMA's position on resident working conditions and supervision, to further clarify the various concerns related to resident working conditions, and to explain why specific language is essential to the general issue of working conditions. (BOT Rep. KKK, A-91; Modified: Sunset Report, I-01)

H-355.979 National Practitioner Data Bank
It is policy of the AMA to improve patient access to reliable information and as an alternative to a federally operated national data repository, our AMA strongly supports and actively encourages the provision of accurate and relevant physician-specific information through a system developed and operated by state licensing boards or other appropriate state agencies. Our AMA: (1) supports requiring felony convictions of physicians to be reported to state licensing boards; (2) supports federal block grants that provide states with sufficient financial resources to develop and implement officially recognized, Internet accessible, physician-specific information systems that will assist patients in choosing physicians; and (3) believes that serious problems exist in correlating lawsuits with physician competence or negligence and some studies indicate lawsuits seldom correlate with findings of incompetence. Only a state licensing board should determine when lawsuit settlements and judgments should result in a disciplinary action, and public disclosure of lawsuit settlements and judgments should only occur in connection with a negative state medical board licensing action. (BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01)
H-355.983 Reporting of Malpractice Information in the National Practitioner Data Bank
Our AMA: (1) seeks opportunities to limit reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; and (2) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in this policy. (CME Rep. 3, A-96; Reaffirmed & Appended: Res. 242, A-01; Reaffirmed: CME Rep. 4, I-01)

H-355.985 National Practitioner Data Bank
Our AMA: (1) opposes all efforts to open the National Practitioner Data Bank to public access; (2) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (3) opposes the implementation by the National Practitioner Data Bank of a self-query user fee. (Res. 824, I-93; Reaffirmed: BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01)

H-355.992 Reporting Impaired Physicians to the National Practitioner Bank
Our AMA will continue to monitor the issue of reporting impaired physicians to the National Practitioner Data Bank and will seek further clarification of ambiguities or misinterpretations of the reporting requirements for impaired physicians. (BOT Rep. J, A-91; Reaffirmed: Sunset Report, I-01)

H-355.993 National Practitioner Data Bank
Our AMA: (1) urges HHS to retain an independent consultant to (a) evaluate the utility and effectiveness of the National Practitioner Data Bank, (b) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (c) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office;

(2) will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank;

(3) opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement;

(4) seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;

(5) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories;

(6) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least $30,000 for the reporting of malpractice payments be established as soon as possible;

(7) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries;
(8) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information;

(9) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure; and

(10) will review questions regarding reportability to the Data Bank and will provide periodic updates on reportability issues to the AMA House of Delegates.

(Sub. Res. 7, A-91; Reaffirmation & Reaffirmed: Res. 216, A-01; Reaffirmed: Sunset Report, I-01)

H-410.986 Resident Involvement in Practice Parameters
Our AMA urges national medical specialty societies to work with resident physicians within their specialty in developing practice parameters.  (Res. 52, A-91; Reaffirmed: Sunset Report, I-01)

H-450.950 Revise National Practitioner Data Bank Criteria
Our AMA: (1) communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and (2) impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank.  (Res. 809, I-99; Reaffirmed: BOT Rep. 31, I-00; Reaffirmation & Reaffirmed: Res. 216, A-01)

D-180.995 Physician Privileges Application -Timely Review by Managed Care
Our AMA will work with the American Association of Health Plans (AAHP), the American Hospital Association (AHA), the National Committee on Quality Assurance (NCQA), and other appropriate organizations to allow residents who are within six months of completion of their training to apply for hospital privileges and acceptance by health plans.  (Res. 708, A-01)

D-255.994 Report on the Fifth Pathway
(1) The "Fifth Pathway Statement" (2001 revision) be disseminated to existing and developing programs, prospective students, and others on request and that adherence to its requirements continue to be monitored. (2) Our AMA will explore ways to collect and disseminate information on the general outcomes of the Fifth Pathway, including such things as graduate specialty choice, performance in residency training, board certification status, and record of disciplinary actions.  (CME Rep. 2, I-01)

D-275.990 Implementation of NBME Clinical Skills Assessment Exam
Our AMA will: (1) request an itemized rationalization from the National Board of Medical Examiners (NBME) for the proposed cost of $1000 for the Clinical Skills Assessment Exam (CSAE) and the number and location of the testing sites; (2) take all steps necessary to delay implementation of the CSAE as the NBME has not developed an implementation plan that involves reasonable geographic and financial structures; and (3) express deep concern to the NBME that the proposed CSAE imposes unacceptable costs and travel burdens on examinees.  (Res. 311, I-01)

D-275.992 Unified Medical License Application
Our AMA will request the Federation of State Medical Boards to examine the issue of a standardized medical licensure application form for those data elements that are common to all medical licensure applications.  (Res. 308, I-01)
D-275.993 Reporting of Resident Physicians
Our AMA will: (1) work with appropriate groups, including the Federation of State Medical Boards, to attempt to increase the standardization of information about resident physicians that is reported to state medical licensing boards to obtain or renew the limited educational permit, consistent with existing AMA Policy H-265.934 (#4); (2) encourage state medical societies to act as a link between state medical licensing boards and medical schools/residency programs to ensure that educational programs are familiar with and have the opportunity to comment on proposed changes in reporting requirements for resident physicians; and (3) make relevant groups--for example, medical schools, state medical societies, resident physicians--aware of what types of information must be supplied in order for resident physicians to obtain and renew a limited educational permit. (CME Rep. 4, I-01)

D-275.994 Facilitating Credentialing for State Licensure
Our AMA will: (1) encourage the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) work with the Federation of State Medical Boards and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; and (3) encourage the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation’s Credentials Verification Service, especially when physicians apply for a new medical license. (Res. 302, A-01)

D-295.977 Implementation of NBME Clinical Skills Assessment Exam
Our AMA representatives to the Liaison Committee on Medical Education (LCME) will indicate that the teaching and assessment of clinical skills should be a high priority in the accreditation process. (Res. 311, I-01)

D-295.978 Mid-Year and Retroactive Medical School Tuition Increases
(1) Our AMA work with the Association of American Medical Colleges to discourage assessment of mid-year and retroactive increases in medical school tuition and fees.

(2) Our AMA encourage state and county medical societies to develop policy and lobby state legislatures to help minimize medical school tuition increases in public or officially-designated state medical schools.

(3) That medical schools provide entering students with an estimate of their future tuition costs and fees, possibly based on past history of the schools tuition.

(4) Our AMA report back to the House of Delegates at the 2002 Interim Meeting on its progress in limiting mid-year and retroactive tuition increases. (Res. 312, I-01)

D-295.979 Education for the Prevention of Professional Liability Lawsuits
Our AMA will work with members of the Federation and other relevant groups to identify and disseminate information about effective programs for the education of medical students, interns, residents, fellows, and young physicians on the prevention of professional liability lawsuits. (Res. 306, I-01)
D-295.980 Web-Based AMCAS Application
Our AMA: (1) will strongly encourage the Association of American Medical Colleges (AAMC) to create a back-up application system that can be used in the event that the web-based American Medical College Application Service (AMCAS) proves inadequate and by applicants who have limited access to computer resources; (2) will strongly encourage the AAMC to work with medical school Admissions Offices to improve and simplify the web-based medical school application; and (3) work in conjunction with the AAMC to encourage medical schools around the country to remain part of the centralized AMCAS in order to avoid placing an undue burden on future applicants through multiple primary applications. (Res. 313, I-01)

D-295.982 Model Pain Management Program For Medical School Curricula
Our AMA will collect, synthesize, and disseminate information about effective educational programs in pain management and palliative care in medical schools and residency programs. (Res. 308, A-01)

D-300.994 Reduced Continuing Medical Education (CME) Fees for Retired Physicians
Our AMA will support reduce registration fees for retired physicians at all continuing medical education programs. (Res. 302, I-01)

D-300.995 Reducing Burdens of CME Accreditation and Documentation
Our AMA will work with the Accreditation Council for Continuing Medical Education to simplify the requirements for documentation and administration of accredited CME programs. (Res. 304, I-01)

D-300.996 Model Pain Management Program For Medical School Curricula
Our AMA will encourage appropriate organizations to support voluntary continuing education for physicians based on effective guidelines in pain management. (Res. 308, A-01)

D-300.997 Use of Medical Education Numbers In Continuing Medical Education
Our AMA will disseminate this policy widely and recommend that such policy be adopted by other organizations, including national certification boards and similar entities. (Res. 301, A-01)

D-300.998 Attendance of Non-Physicians at Courses Teaching Complex Diagnostic, Therapeutic or Surgical Procedures
Our AMA will encourage the Accreditation Council for Continuing Medical Education, the American Academy of Family Physicians, and other groups that accredit providers of continuing medical education to adopt the principle that continuing medical education should be focused on physicians (MDs/DOs). Courses teaching complex diagnostic, therapeutic or surgical procedures should be open only to those practitioners and/or sponsored members of the practitioner’s care team who have the appropriate medical education background and preparation to ensure patient safety. This should not be construed to limit access to or apply to programs leading to life support certification, e.g. ATLS, ACLS. (CME Rep. 2, A-01)

D-305.990 Impact of Health System Changes on Medical Education
Our AMA will continue to monitor the financial status of academic medical centers and the availability of faculty and patients to support the clinical education of medical students and resident physicians. This should both include collecting information and synthesizing information from other sources on these issues. (CME Rep. 4, A-01)
D-305.991 Tax Deductibility for Student Loan Interest
Our AMA will continue to actively lobby for a minimum inflation-indexed gross income phaseout of $115,000 ($165,000 for joint filers), while continuing to advocate for the elimination of all gross income thresholds. (Res. 244, A-01)

D-310.990 Resident/Fellow Work and Learning Environment
Our AMA will: (1) work with organizations such as the Accreditation Council for Graduate Medical Education (ACGME), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and other appropriate organizations, toward finding solutions to the problem of work hours and conditions which would strengthen current work hours enforcement mechanisms; and (2) encourage the Agency for Healthcare Research and Quality (AHRQ) to examine the link between resident work hours and patient safety and to explore possible solutions to the problem of work hours and conditions. (Res. 310, I-01)

D-310.991 Intern and Resident Working Hours
The ACGME: (1) through its Residency Review Committees (RRC) and the Institutional Review Committee, enforce work hour guidelines rigorously and ensure compliance with work hour standards; and (2) be requested to investigate mechanisms to provide readily accessible, timely and accurate information about work hours for individual programs that is not constrained by the cycle of survey visits. (CME Rep. 1, I-01)

D-310.992 Limits on Training Opportunities for J-1 Residents
Our AMA will request that the Bureau of Educational and Cultural Affairs, Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties and the Educational Commission for Foreign Medical Graduates develop criteria by which J-1 exchange visitor physicians could seek extension of the length of their visa beyond the 7-year limit in order to participate in fellowship or subspecialty programs accredited by the ACGME. (Res. 303, A-01)

D-310.993 Fair Process for Physicians-In-Training
Our AMA will distribute to Graduate Medical Education programs the model resident contract language for fair process set forth in this report, for use in establishing procedures in conformity with the Institutional Requirements of the American College of Graduate Medical Education and the CEJA Opinion on Due Process (9.05). (BOT Rep. 19, A-01)

D-355.997 Reporting of Resident Physicians
Our AMA will: (1) continue to monitor the types of information reported about resident physicians to federal and state agencies, especially the National Practitioner Data Bank and state medical licensing boards; and (2) draft and advocate for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with policy H-355.983, and oppose the expansion of existing reporting requirements. (CME Rep. 4, I-01)

D-360.997 The Effect of Nursing Shortage on Medical Education
Our AMA will study and report back the effects of the nursing shortage on the working environment of physicians-in-training. (Res. 309, I-01)