Handbook Review: HOD Reference Committee C (Medical Education)

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HOD resolution or report (sponsor)	Action requested	AMA-YPS recommended position
CME Report 1: Competency of Senior Physicians	SUMMARY AND RECOMMENDATIONS The Council on Medical Education concurs that physicians should be allowed to remain in practice as long as patient safety is not endangered, and they are providing appropriate and effective treatment. However, data and anecdotal information support the development of guidelines for the screening and assessment of senior/late career physicians. The variations around cognitive skills as physicians age, as well as the changing demographics of the physician workforce, are also key factors contributing to this need. It is critical that physicians take the lead in developing standards for monitoring and assessing their personal competency and that of fellow physicians to head off a call for nationally implemented mandatory retirement ages or imposition of guidelines by others. The guiding principles outlined in this report provide direction and serve as a reference for setting priorities and standards for further action. The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed. 1. That our American Medical Association (AMA) make available to all interested parties the Assessment of Senior/Late Career Physicians Guiding Principles: a) Evidence-based: The development of guidelines for assessing and screening senior/late career physicians is based on evidence of the importance of cognitive changes associated with aging that are relevant to physician performance. Current research suggests that physician competency and practice performance decline with increasing years in practice. However, research also suggests that the effect of age on an individual physician's competency can be highly variable, and wide variations are seen in cognitive performance with aging. b) Ethical: Guidelines should be based on the principles of medical ethics. Self-regulation is an important aspect of medical professionalism. Physicians should be involved in the development of guidelines/standards for monitoring and assessing both their own and their colleagues' competency. c) Relevant: Guidelines, procedures, or methods of assessment should be relevant to physician practices to inform judgments and provide feedback regarding physicians'	Support

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	ability to perform the tasks specifically required in their practice environment. d) Accountable: The ethical obligation of the profession to the health of the public and patient safety should be the primary driver for establishing guidelines and informing decision making about physician screening and assessment results. e) Fair and equitable: The goal of screening and assessment is to optimize physician competency and performance through education, remediation, and modifications to physicians' practice environment or scope. Unless public health or patient safety is directly threatened, physicians should retain the right to modify their practice environment to allow them to continue to provide safe and effective care. When public health or patient safety is directly threatened, removal from practice is one potential outcome. f) Transparent: Guidelines, procedures or methods of screening and assessment should be transparent to all parties, including the public. Physicians should be aware of the specific methods used, performance expectations and standards against which performance will be judged, and the possible outcomes of the screening or assessment. g) Supportive: Education and/or remediation practices that result from screening and /or assessment procedures should be supportive of physician wellness, ongoing, and proactive. h) Cost conscious: Procedures and screening mechanisms that are distinctly different from "for cause" assessments should not result in undue cost or burden to senior physicians providing patient care. Hospitals and health care systems should provide easily accessible screening assessments for their employed senior physicians. Similar procedures and screening mechanisms should be available to senior physicians who are not employed by hospitals and health care systems. (New HOD Policy) 2. That our AMA encourage the Federation of State Medical Boards, Council of Medical Specialty Societies, and other interested organizations to develop educational materials on the effects of age on physician practice for senior/late career physicians. (Directive to Take Action) 3. That Policy D-275.956, "Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians," be rescinded, as having been fulfilled by this report. (Rescind HOD	

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	Policy) Fiscal note: $1,000	
CME Report 3: Developing Physician-Led Public Health/Population Health Capacity in Rural Communities	SUMMARY AND RECOMMENDATIONS Leadership in public and population health remains an important topic deserving of continued interest within the community of medicine. In addition to the ongoing focus on available training opportunities related to public/population health leadership for physicians and medical students, attention should be directed to the future composition of the country's public health leaders. A recent study found that 73 percent of deans of schools of public health were male, and 70 percent received their terminal degree more than 35 years ago; 64 percent of state health directors received their terminal degree more than 25 years ago; and 26 percent of state health directors hold no terminal degree.[14] There is no evidence to suggest that these individuals are anything other than effective, dedicated leaders who are passionate about promoting public/population health in their communities and throughout the country. However, these statistics should perhaps spark a discussion within the medical community regarding how individuals are currently encouraged and incentivized to enter public health leadership positions, and how to ensure that current public/population health leaders are actively engaging in relevant lifelong learning. The Council on Medical Education therefore recommends that the following recommendations be adopted and the remainder of the report be filed: 1. That Policy D-295.311, "Developing Physician Led Public Health / Population Health Capacity in Rural Communities," be rescinded, as having been fulfilled by this report. (Rescind HOD Policy) 2. That our American Medical Association (AMA) reaffirm the following policies: D-295.327, "Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum" D-305.964, "Support for the Epidemic Intelligence Service (EIS) Program and Preventive Medicine Residency Expansion" D-305.974, "Funding for Preventive Medicine Residencies" H-425.982, "Training in the Principles of Population-Based Medicine" D-440.951, "One-Year Public Health Training Options for all Specialties" H-440.954, "Revitalization of Local Public Health Units for the Nation" H-440.888, "Public Health Leadership" H-440.969, "Meeting Public Health Care Needs Through Health Professions Education" (Reaffirm HOD Policy)	Support

Handbook Review: HOD Reference Committee C (Medical Education)

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	3. That our AMA encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and Accreditation Council for Graduate Medical Education (ACGME) to highlight public/population health leadership learning opportunities to all learners, but especially to women and those who are underrepresented in medicine. (Directive to Take Action) 4. That our AMA encourage public health leadership programs to evaluate the effectiveness of various leadership interventions. (Directive to Take Action) Fiscal Note: $1,000.	
CME Report 4: Reconciliation of AMA Policy on Primary Care Workforce	SUMMARY AND RECOMMENDATIONS This report encompasses a review of current AMA policies on primary care workforce to ensure such policy is consistent, accurate and up-to-date. The new policy being proposed in recommendation 1, below, incorporates relevant portions of the 13 existing policies that are recommended for rescission in recommendation 2. Appendices A and B show a worksheet version and a clean text version, respectively, of the policy that is being proposed for adoption. Appendix C lists the 13 existing policies that are proposed for rescission. Policy H-200.972, "Primary Care Physicians in the Inner City," contained elements that were not germane to the newly proposed policies. Accordingly, this policy is recommended for revision, as shown below, with the deleted portions to be reflected in the proposed policy. In addition, the policy's content and title have been expanded to reflect rural as well as urban populations of underserved patients. The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed: 1. That our American Medical Association (AMA) adopt as policy "Principles of and Actions to Address Primary Care Workforce" the language shown in column 1 in Appendix A to this report. (New HOD Policy) 2. That our AMA rescind the following policies, as shown in Appendix C: 1. D-200.979, "Barriers to Primary Care as a Medical School Choice"	**Active Support with Amendment to resolve the inconsistency in column A versus B in item 8 of appendix A.**

	2. D-200.994, "Appropriations for Increasing Number of Primary Care Physicians" 3. H-200.956, "Appropriations for Increasing Number of Primary Care Physicians" 4. H-200.966, "Federal Financial Incentives and Medical Student Career Choice" 5. H-200.973, "Increasing the Availability of Primary Care Physicians" 6. H-200.975, "Availability, Distribution and Need for Family Physicians" 7. H-200.977, "Establishing a National Priority and Appropriate Funding for Increased Training of Primary Care Physicians" 8. H-200.978, "Loan Repayment Programs for Primary Care Careers" 9. H-200.982, "Significant Problem of Access to Health Care in Rural and Urban Underserved Areas" 10. H-200.997, "Primary Care" 11. H-295.956, "Educational Grants for Innovative Programs in Undergraduate and Residency Training for Primary Care Careers" 12. H-300.957, "Promoting Primary Care Services Through Continuing Medical Education" 13. H-310.973, "Primary Care Residencies in Community Hospitals" (Rescind HOD Policy) 3. That H-200.972, "Primary Care Physicians in the Inner City," be amended by addition and deletion, and a title change, to read as follows: "Primary Care Physicians in Underserved Areas" Our AMA should pursue the following plan to improve the recruitment and retention of physicians in ~~the inner city~~ underserved areas: (1) Encourage the creation and pilot-testing of school-based, ~~church~~ faith-based, and community-based urban/rural "family ~~H~~health clinics, with an emphasis on health education, prevention, primary care, and prenatal care. (2) Encourage the affiliation of these family health clinics with ~~urban~~ local medical schools and teaching hospitals. ~~(3) Promote medical student rotations through the various inner-city neighborhood family health clinics, with financial assistance to the clinics to compensate their teaching efforts.~~ ~~(4) Encourage medical schools and teaching hospitals to integrate third- and fourth year undergraduate medical education and residency training into these teams.~~	

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	(~~5~~3) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies. (6) ~~Study the concept of having medical schools with active outreach programs in the inner city offer additional training to physicians from nonprimary care specialties who are interested in achieving specific primary care competencies.~~ ~~(7) Consider expanding opportunities for practicing physicians in other specialties to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family practice, internal medicine, pediatrics, etc. These may be developed so that they are part-time, thereby allowing physicians enrolling in these programs to practice concurrently.~~ (~~8~~4) Encourage the AMA Senior Physicians ~~Services Group~~ Section to consider the ~~use~~ involvement of retired physicians in underserved ~~urban~~ settings ~~of retired physicians~~, with appropriate mechanisms to ensure their competence. (~~9~~5) Urge urban hospitals and medical societies to develop opportunities for physicians to work part-time to staff ~~urban~~ health clinics that help meet the needs of underserved patient populations. (~~10~~6) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who ~~serve the inner-city poor~~ help meet the needs of underserved patient populations. ~~(11) Urge medical schools to seek out those students whose profiles indicate a likelihood of practicing in underserved urban areas, while establishing strict guidelines to preclude discrimination.~~ ~~(12) Encourage medical school outreach activities into secondary schools, colleges, and universities to stimulate students with these profiles to apply to medical school.~~ ~~(13) Encourage medical schools to continue to change their curriculum to put more emphasis on primary care.~~ ~~(14) Urge state medical associations to support the development of methods to improve physician compensation for serving this population, such as Medicaid case management programs in their respective states.~~	

Handbook Review: HOD Reference Committee C (Medical Education)

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	(~~15~~7) Urge ~~urban~~ hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to ~~fill gaps in urban care~~ help meet the needs of underserved patient populations. ~~(16) Urge CMS to explore the use of video and computer capabilities to improve access to and support for urban primary care practices in underserved settings.~~ ~~(17) Urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.~~ ~~(18) Continue to urge measures to enhance payment for primary care in the inner city.~~ (Modify Current HOD Policy) Fiscal note: $1,000.	
*CME Report 5: Reconciliation of AMA Policy on Medical Student Debt	SUMMARY AND RECOMMENDATIONS This report encompasses a review of current AMA policies on medical student debt to ensure such policy is consistent, accurate and up-to-date. The new policy being proposed in recommendation 1, below (shown in Appendix A), incorporates relevant portions of the 21 existing policies that are recommended for rescission in recommendation 2. Appendix B shows a clean text version of the policy that is being proposed for adoption. Appendix C lists all 21 policies that are proposed for rescission. The (relatively few) segments of policy that are not being retained in the proposed new policy are listed in Appendix D. The Council on Medical Education therefore recommends that the following recommendations be adopted and that the remainder of the report be filed: 1. That our American Medical Association (AMA) adopt as policy "Principles of and Actions to Address Medical Education Costs and Student Debt" the language shown in column 1 of Appendix A of this report. (New HOD Policy) 2. That our AMA rescind the following policies, as shown in Appendix C: 1. D-305.956, "AMA Participation in Reducing Medical Student Debt" 2. D-305.957, "Update on Financial Aid Programs" 3. D-305.962, "Tax Deductibility of Student Loan Payments" 4. D-305.966, "Reinstatement of Economic Hardship Loan Deferment" 5. D-305.970, "Proposed Revisions to AMA Policy on Medical Student Debt"	Support

Handbook Review: HOD Reference Committee C (Medical Education)

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	6. D-305.975, "Long-Term Solutions to Medical Student Debt" 7. D-305.977, "Deductibility of Medical Student Loan Interest" 8. D-305.978, "Mechanisms to Reduce Medical Student Debt" 9. D-305.979, "State and Local Advocacy on Medical Student Debt" 10. D-305.980, "Immediate Legislative Solutions to Medical Student Debt" 11. D-305.981, "Financing Federal Consolidation Loans" 12. D-305.993, "Medical School Financing, Tuition, and Student Debt" 13. D-405.986, "Student Loans and Medicare / Medicaid Participation" 14. H-305.926, "Supporting Legislation to Create Student Loan Savings Accounts" 15. H-305.928, "Proposed Revisions to AMA Policy on Medical Student Debt" 16. H-305.932, "State and Local Advocacy on Medical Student Debt" 17. H-305.948, "Direct Loan Consolidation Program" 18. H-305.954, "Repayment of Medical School Loans" 19. H-305.965, "Student Loans" 20. H-305.980, "Student Loan Repayment Grace Period" 21. H-305.991, "Repayment of Educational Loans" (Rescind HOD Policy) Fiscal note: $1,000.	
CME Report 6: Reconciliation of AMA Policy on Resident/Fellow Contracts and Duty Hours	SUMMARY AND RECOMMENDATIONS The Council on Medical Education therefore recommends that the following recommendations adopted and that the remainder of the report be filed: 1. That our American Medical Association (AMA) adopt the proposed revisions shown in Appendix A, column 1, for the following three policies: 1) H-310.907, "AMA Duty Hours Policy" (with revised title: "Resident/Fellow Clinical and Educational Work Hours") 2) H-310.912, "Residents and Fellows' Bill of Rights" 3) H-310.929, "Principles for Graduate Medical Education" (Modify Current HOD Policy) 2. That our AMA rescind the following seven policies, as shown in Appendix C, and incorporate relevant portions of four of these policies into existing AMA policy: 1) D-310.987, "Impact of ACGME Resident Duty Hour Limits on Physician Well-Being and Patient Safety" 2) H-310.922, "Determining Residents' Salaries"	Support

Handbook Review: HOD Reference Committee C (Medical Education)

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	3) H-310.932, "Annual Contracts for Continuing Residents" 4) H-310.947, "Revision of the 'General Requirements' of the Essentials of Accredited Residency Programs" 5) H-310.979, "Resident Physician Working Hours and Supervision" 6) H-310.988, "Adequate Resident Compensation" 7) H-310.999, "Guidelines for Housestaff Contracts or Agreements" (Rescind HOD Policy) Fiscal note: $1,000.	
Resolution 951: Prevention of Physician and Medical Student Suicide Introduced by: Resident and Fellow Section	RESOLVED, That our American Medical Association request that the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education collect data on medical student, resident and fellow suicides to identify patterns that could predict such events. (Directive to Take Action) Fiscal Note: Minimal - less than $1,000	**Active Support with Amendment** RESOLVED, That our American Medical Association request that the Liaison Committee on Medical Education, ~~and~~ the Accreditation Council for Graduate Medical Education and the Commission on Osteopathic College Accreditation collect data on medical student, resident and fellow and attending physician suicides to identify patterns that could predict such events. (Directive to Take Action)
Resolution 952: IMG Section Member Representation on Committees/Task Forces/Councils Introduced by:	RESOLVED, That the American Medical Association ask the Educational Commission for Foreign Medical Graduates (ECFMG) to increase the number of international medical graduates (IMGs) proportionate to the percentage of IMGs serving in the U.S. on their councils, committees, and/or task forces. (Directive to Take Action) Fiscal Note: Minimal - less than $1,000.	Monitor

Handbook Review: HOD Reference Committee C (Medical Education)

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International Medical Graduates Section		
Resolution 953: Support for the Income-Driven Repayment Plans Introduced by: Resident and Fellow Section	RESOLVED, That our American Medical Association advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student loan burden. (New HOD Policy) Fiscal Note: Modest - between $1,000 - $5,000.	**Active Support**
Resolution 954: VHA GME Funding Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Society of Dermatopathology	RESOLVED, That our American Medical Association continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions (Directive to Take Action); and be it further RESOLVED, That our AMA collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration (VHA) funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process (Directive to Take Action); and be it further RESOLVED, That our AMA oppose service obligations linked to VHA GME residency or fellowship positions, particularly for resident physicians rotating through the VA for only a portion of their GME training. (New HOD Policy) Fiscal Note: Modest - between $1,000 - $5,000.	Support
Resolution 955: Equality for COMLEX and USMLE Introduced by: Medical Student Section	RESOLVED, That our American Medical Association promote equal acceptance of the USMLE and COMLEX at all United States residency programs (New HOD Policy); and be it further RESOLVED, That our AMA work with appropriate stakeholders including but not limited to the National Board of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores (Directive to Take Action); and be it further RESOLVED, That our AMA work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system. (Directive to Take Action)	Support

Handbook Review: HOD Reference Committee C (Medical Education)

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	Fiscal Note: Modest - between $1,000 - $5,000.	
Resolution 956: Increasing Rural Rotations During Residency Introduced by: Nebraska	RESOLVED, That our American Medical Association work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to encourage and incentivize qualified rural physicians to serve as preceptors, volunteer faculty, etc. for rural rotations in residency (Directive to Take Action); and be it further RESOLVED, That our AMA work with the ACGME, the American Board of Medical Specialties, the Federation of State Medical Boards, CMS and other interested stakeholders to lessen or remove regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas (Directive to Take Action); and be it further RESOLVED, That our AMA work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates (Directive to Take Action); and be it further RESOLVED, That our AMA work with state and specialty societies and other interested stakeholders to identify appropriately qualified rural physicians who would be willing to serve as preceptors for rural rotations in residency (Directive to Take Action); and be it further RESOLVED, That our AMA work with the ACGME and other interested stakeholders to lessen the documentation requirements for off-site rural rotations during residency so that affiliated rural supervising faculty can focus on educating rotating residents (Directive to Take Action); and be it further RESOLVED, That our AMA work with interested stakeholders 1 to study other ways to increase training in rural areas (Directive to Take Action); and be it further RESOLVED, That our AMA formulate an actionable plan of advocacy based on the results of the above study with the goal of increasing residency training in rural areas. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	**Active Support**
Resolution 957: Board Certifying	RESOLVED, That our American Medical Association conduct a study of the certifying bodies that compete with the American Board of Medical Specialties and issue a report opining on	**Active Oppose**

Handbook Review: HOD Reference Committee C (Medical Education)

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Bodies Introduced by: Florida	the qualifications of each such certifying body and whether each such certifying body should be added to the list of approved certifying entities in states where they are not currently approved (Directive to Take Action); and be it further RESOLVED, That our AMA develop model state legislation that would encourage competition among qualified certifying bodies and would modify board certification requirements such that maintenance of certification participation would not be a requirement for board recertification. (Directive to Take Action) Fiscal Note: Estimated cost to implement the resolution is $30,000.	
*Resolution 958: National Health Service Corps Eligibility Introduced by: California	RESOLVED, That our American Medical Association consider eligibility criteria changes for the National Health Service Corps Program to increase the pool of eligible physicians, such as allowing participation from primary care physicians providing in-patient hospitalist care in health professional shortage areas. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	Monitor
*Resolution 959: Physician and Medical Student Mental Health and Suicide Introduced by: Indiana	RESOLVED, That our American Medical Association create a new Physician and Medical Student Suicide Prevention Committee with the goal of addressing suicides and mental health disease in physicians and medical students. This committee will be charged with: 1) Developing novel policies to decrease physician and medical trainee stress and improve professional satisfaction. 2) Vociferous, repeated and widespread messaging to physicians and medical students encouraging those with mood disorders to seek help. 3) Working with state medical licensing boards and hospitals to help remove any stigma of mental health disease and to alleviate physician and medical student fears about the consequences of mental illness and their medical license and hospital privileges. 4) Establishing a 24-hour mental health hotline staffed by mental health professionals whereby a troubled physician or medical student can seek anonymous advice. Communication via the 24-hour help line should remain anonymous. This service can be directly provided by the AMA or could be arranged through a third party, although volunteer physician counselors may be an option for this 24-hour phone service. (Directive to Take Action) Fiscal Note: Not yet determined	Monitor
*Resolution 960:	RESOLVED, That our American Medical Association adopt policy to establish parity between	Oppose

Handbook Review: HOD Reference Committee C (Medical Education)

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Inadequate Residency Slots Introduced by: Indiana	the number of medical school graduates and the number of match positions and withhold support for any further increase in medical school enrollment, unless there is a corresponding increase in residency positions (New HOD Policy); and be it further RESOLVED, That our AMA lobby the federal government for increased funding for residency spots, to investigate other sustainable models for residency position funding and to advocate for loan repayment waivers for individuals who fail to match. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	
*Resolution 961: Protect Physician-Led Medical Education Introduced by: Michigan	RESOLVED, That our American Medical Association, in their role as a member organization of the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education, strongly advocate for the rights of medical students, residents, and fellows to be trained, supervised, and evaluated by licensed physicians (Directive to Take Action); and be it further RESOLVED, That our AMA provide medical students, residents, and fellows a clear online resource outlining their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation. (Directive to Take Action) Fiscal Note: Modest - between $1,000 - $5,000.	**Active Referral**
*Resolution 962: Improve Physician Health Programs Introduced by: Michigan WITHDRAWN	RESOLVED, That our American Medical Association amend policy D-405.990, "Educating Physicians About Physician Health Programs," by addition to read as follows: 1) Our AMA will work closely with the Federation of State Physician Health Programs (FSPHP) to educate our members as to the availability and services of state physician health programs to continue to create opportunities to help ensure physicians and medical students are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory; 2) Our AMA will continue to collaborate with relevant organizations on activities that address physician health and wellness; 3) Our AMA will, in conjunction with the FSPHP, develop state legislative guidelines addressing the design and implementation of physician health programs; ~~and~~ 4) Our AMA will work with FSPHP to develop messaging for all Federation members to consider regarding elimination of stigmatization of mental illness and illness in general in physicians and physicians in training; 5) Our AMA will advocate for more independent oversight and regulation of Physician Health Programs (PHPs), by physician groups without any conflict of interest	WITHDRAWN

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	with the participating PHPs; and 6) Our AMA advocate for Physician Health Programs that allow physicians to access more than one type of treatment program. (Modify Current HOD Policy) Fiscal Note: Minimal - less than $1,000.	

*Included in the Handbook Addendum
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