HOD ACTION: Council on Medical Education Report 1 adopted, and the remainder of the report filed.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-19

Subject: Council on Medical Education Sunset Review of 2009 House Policies

Presented by: Carol Berkowitz, MD, Chair

Referred to: Reference Committee C
(Nicole Riddle, MD, Chair)

AMA Policy G-600.110, "Sunset Mechanism for AMA Policy," is intended 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. The current policy reads as follows:

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

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

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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.

4. The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.

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1 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
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3 6. Sunset policies will be retained in the AMA historical archives.
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5 The Council on Medical Education's recommendations on the disposition of the 2009 House
6 policies that were assigned to it are included in the Appendix to this report.
7
8 RECOMMENDATION
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10 The Council on Medical Education recommends that the House of Delegates policies listed in the
11 appendix to this report be acted upon in the manner indicated and the remainder of this report be
12 filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS ON 2009 AND OTHER RELATED HOUSE OF DELEGATES POLICIES

Policy Number, Title, Policy	Recommended Action

H-30.983, "Medical Education on Alcoholism and Other Chemical Dependencies"

Policy	Recommended Action
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; Reaffirmed: CME Rep. 2, A-09)	Retain; still relevant.

H-200.957, "Proper Notification and Education Regarding Healthcare Professional Shortage Areas by Medicare Carrier"

Policy	Recommended Action
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; Reaffirmed: CME Rep. 2, A-09)	Retain; still relevant.

D-200.998, "Physician Workforce Planning and Physician Re-Training"

Policy	Recommended Action
Our AMA will consider physician retraining during all its deliberations on physician workforce planning. (Res. 324, A-99; Reaffirmed and Modified: CME Rep. 2, A-09	Retain through incorporation into H-200.955, "Revisions to AMA Policy on the Physician Workforce," as follows: (9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning.

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

Policy	Recommended Action
(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	Sunset; directive has been accomplished through reports from both Councils.

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; Reaffirmed: CME Rep. 2, A-09)	

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; Reaffirmed: CME Rep. 2, A-09)	Retain; still relevant.

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	Retain; still relevant.

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; Reaffirmed: CME Rep. 2, A-09)	

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; Reaffirmed: CME Rep. 2, A-09)	Sunset; superseded by other policies on IMGs, including H-255.988, "AMA Principles on International Medical Graduates" and D-255.982, "Oppose Discrimination in Residency Selection Based on International Medical Graduate Status." Through the work of its IMG Section and related initiatives, the AMA is a preeminent advocate for IMGs.

D-275.963, "Ensuring Diversity in United States Medical Licensing Examination Exams"

Our AMA will pursue diversity on all United States Medical Licensing Examination test/oversight committees in order to include the perspectives from others, including international medical graduates, to better reflect the diversity of the test takers. (Sub. Res. 306, A-09)	Retain; still relevant.

D-295.319, "Discriminatory Questions on Applications for Medical Licensure"

Our American Medical Association will work with the Federation of State Medical Boards and other appropriate stakeholders to develop model language for medical licensure applications which is non discriminatory and which does not create barriers to appropriate	Sunset; superseded by H-275.970, "Licensure Confidentiality," which reads: "1. The AMA (a) encourages specialty boards, hospitals, and other organizations involved in credentialing, as well as state licensing boards,

diagnosis and treatment of psychiatric disorders, consistent with the responsibility of state medical boards to protect the public health. (Res. 925, I-09)	to take all necessary steps to assure the confidentiality of information contained on application forms for credentials; (b) encourages boards to include in application forms only requests for information that can reasonably be related to medical practice; (c) encourages state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training; (d) encourages state medical societies and specialty societies to join with the AMA in efforts to change statutes and regulations to provide needed confidentiality for information collected by licensing boards; and (e) encourages state licensing boards to require disclosure of physical or mental health conditions only when a physician is suffering from any condition that currently impairs his/her judgment or that would otherwise adversely affect his/her ability to practice medicine in a competent, ethical, and professional manner, or when the physician presents a public health danger. "2. Our AMA will encourage those state medical boards that wish to retain questions about the health of applicants on medical licensing applications to use the language recommended by the Federation of State Medical Boards that reads, "Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical and professional manner? (Yes/No)."

D-295.325, "Remediation Programs for Physicians"

1. Our AMA supports the efforts of the Federation of State Medical Boards (FSMB) to maintain an accessible national repository on remediation programs that provides information to interested stakeholders and allows the medical profession to study the issue on a national level. 2. Our AMA will collaborate with other appropriate organizations, such as the FSMB and the Association of American Medical Colleges, to study and develop effective methods and tools to assess the effectiveness of	Retain; still relevant.

physician remediation programs, especially the relationship between program outcomes and the quality of patient care. 3. Our AMA supports efforts to remove barriers to assessment programs including cost and accessibility to physicians. 4. Our AMA will partner with the FSMB and state medical licensing boards, hospitals, professional societies and other stakeholders in efforts to support the development of consistent standards and programs for remediating deficits in physician knowledge and skills. 5. Our AMA will ask the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to develop standards that would encourage medical education programs to engage in early identification and remediation of conditions, such as learning disabilities, that could lead to later knowledge and skill deficits in practicing physicians. (CME Rep. 3, A-09)	

D-295.326, "Recognition of Osteopathic Education and Training"

Our AMA will explore the feasibility of collaborating with other stakeholder organizations and funding agencies to convene leaders in allopathic and osteopathic medicine responsible for undergraduate and graduate medical education, accreditation and certification, to explore opportunities to align educational policies and practices. (CME Rep. 12, A-09)	Sunset; this is being accomplished at the graduate medical education level through the Single GME Accreditation System.

D-295.328, "Promoting Physician Lifelong Learning"

1. Our AMA encourages medical schools and residency programs to explicitly include training in and an evaluation of the following basic skills: (a) the acquisition and appropriate utilization of information in a time-effective manner in the context of the care of actual or simulated patients; (b) the identification of information that is evidence-based, including such things as data quality, appropriate data analysis, and analysis of bias of any kind; (c) the ability to assess one's own learning needs and to create an appropriate learning plan;	Retain; still relevant.

(d) the principles and processes of assessment of practice performance; (e) the ability to engage in reflective practice. 2. Our AMA will work to ensure that faculty members are prepared to teach and to demonstrate the skills of lifelong learning. 3. Our AMA encourages accrediting bodies for undergraduate and graduate medical education to evaluate the performance of educational programs in preparing learners in the skills of lifelong learning. 4. Our AMA will monitor the utilization and evolution of the new methods of continuing physician professional development, such as performance improvement and internet point-of-care learning, and work to ensure that the methods are used in ways that are educationally valid and verifiable. 5. Our AMA will continue to study how to make participation in continuing education more efficient and less costly for physicians. (CME Rep. 10, A-09)	

D-295.329, "Communication and Clinical Teaching Curricula"

Our AMA will: 1. encourage the Liaison Committee on Medical Education to continue to enforce accreditation standards requiring that faculty members and resident physicians are prepared for and evaluated on their teaching effectiveness; 2. encourage the Accreditation Council for Graduate Medical Education to create institutional-level standards related to assuring the quality of faculty teaching; 3. encourage medical schools and institutions sponsoring graduate medical education programs to offer faculty development for faculty and resident physicians in time-efficient modalities, such as online programs, and/or to support faculty and resident participation in off-site programs; 4. encourage medical educators to develop and utilize valid and reliable measures for teaching effectiveness; and 5. encourage medical schools to recognize participation in faculty development for purposes of faculty retention and promotion. (CME Rep. 9, A-09)	Retain; still relevant.

D-295.330, "Update on the Uses of Simulation in Medical Education"

Our AMA will: 1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment; 2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs; 3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance; 4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands; 5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and 6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum. (CME Rep. 8, A-09)	Retain; still relevant.

H-295.867, "Expanding the Visiting Students Application Service for Visiting Student Electives in the Fourth Year"

1. Our American Medical Association strongly encourages the Association of American Medical Colleges (AAMC) to expand eligibility for the Visiting Students Application Service (VSAS) to medical students from Commission on Osteopathic College Accreditation (COCA)-accredited medical schools. 2. Our AMA supports and encourages the AAMC in its efforts to increase the number of members and non-member programs in the VSAS, such as medical schools accredited by	Retain; still relevant.

COCA and teaching institutions not affiliated with a medical school. 3. Our AMA encourages the AAMC to ensure that member institutions that previously accepted both allopathic and osteopathic applications for fourth year clerkships prior to VSAS implementation continue to have a mechanism for accepting such applications of osteopathic medical students. (Res. 910, I-09)	

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; Reaffirmed: CME Rep. 2, A-09)	Sunset; superseded by D-295.988, "Clinical Skills Assessment During Medical School," which reads in part: "1. 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… "3. Our AMA will work to … include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency. "4. Our AMA is committed to assuring that all medical school graduates entering graduate medical education programs have demonstrated competence in clinical skills. "5. Our AMA will continue to work with appropriate stakeholders to assure the processes for assessing clinical skills are evidence-based and most efficiently use the time and financial resources of those being assessed."

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; Reaffirmed: CME Rep. 2, A-09)	Retain; still relevant.

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; Reaffirmed: CME Rep. 2, A-09)	Retain; still relevant.

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. (Sub. Res. 309, A-95; Reaffirmed and Appended: CME Rep. 3, I-99; Reaffirmed and Modified: CME Rep. 2, A-09)	Sunset; this has become well established in medical education and practice.

H-295.949, "Encouraging Community Based Medical Education"

Our AMA recognizes and acknowledges the vital role of practicing physicians in community hospitals in medical student and resident teaching. (Res. 44, A-91; Modified: Sunset Report, I-01; Reaffirmed: CME Rep. 9, A-09)	Retain through incorporation into H-295.916, "Improving Medical School/Community Practice," as follows: 1. Our AMA recognizes and acknowledges the vital role of practicing physicians in community hospitals in medical student and resident teaching. ~~1~~2. Medical schools should be encouraged to include community physicians who serve as volunteer faculty in medical school activities and in committees and other decision-making bodies related to the student educational program, such as the curriculum committee and the admission committee, and in search committees for medical school deans and department chairs. ~~2~~3. County/state medical societies should be encouraged to include medical school administrators and faculty members in committees and other society activities, and to consider creating a seat for medical school deans in the state society house of delegates. ~~3~~4. There should be mechanisms established at local or state levels to address tensions arising between the academic and practice communities, such as problems associated with the granting of faculty appointment or hospital staff privileges.

	~~4~~5. Medical schools and other academic continuing medical education providers should work with community physicians to develop continuing education programs that address local needs. ~~5~~6. Community physician groups and schools of medicine should be encouraged to communicate during the initial stages of discussions about the formation of patient care networks.

D-295.983, "Fostering Professionalism During Medical School and Residency Training"

(1) Our AMA, in consultation with other relevant medical organizations and associations, will work to develop a framework for fostering professionalism during medical school and residency training. This planning effort should include the following elements: (a) Synthesize existing goals and outcomes for professionalism into a practice-based educational framework, such as provided by the AMA's Principles of Medical Ethics. (b) Examine and suggest revisions to the content of the medical curriculum, based on the desired goals and outcomes for teaching professionalism. (c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees? acquisition of professionalism. (d) Create means to incorporate ongoing collection of feedback from trainees about factors that support and inhibit their development of professionalism. (2) Our AMA, along with other interested groups, will continue to study the clinical training environment to identify the best methods and practices used by medical schools and residency programs to fostering the development of professionalism. (CME Rep. 3, A-01; Reaffirmation I-09)	Retain; still relevant, with editorial change as shown below: (c) Identify methods for teaching professionalism and those changes in the educational environment, including the use of role models and mentoring, which would support trainees~~?~~' acquisition of professionalism.

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; Reaffirmed: CME Rep. 2, A-09	Sunset; superseded by the following policies, as excerpted below. H-295.961, "Medicolegal, Political, Ethical and Economic Medical School Course" "The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses..." H-295.953, "Medical Student, Resident and Fellow Legislative Awareness" "1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students. "2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum. "3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows. "4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows." H-295.977, "Socioeconomic Education for Medical Students" "1. The AMA favors (a) continued monitoring of U.S. medical school curricula and (b) providing encouragement and assistance to medical school administrators to include or

	maintain material on health care economics in medical school curricula. “2. Our AMA will advocate that the medical school curriculum include an optional course on coding and billing structure, RBRVS, RUC, CPT and ICD-9.” H-295.924, “Future Directions for Socioeconomic Education” “The AMA: (1) asks medical schools and residencies to encourage that basic content related to the structure and financing of the current health care system, including the organization of health care delivery, modes of practice, practice settings, cost effective use of diagnostic and treatment services, practice management, risk management, and utilization review/quality assurance, is included in the curriculum; (2) asks medical schools to ensure that content related to the environment and economics of medical practice in fee-for-service, managed care and other financing systems is presented in didactic sessions and reinforced during clinical experiences, in both inpatient and ambulatory care settings, at educationally appropriate times during undergraduate and graduate medical education; and (3) will encourage representatives to the Liaison Committee on Medical Education (LCME) to ensure that survey teams pay close attention during the accreditation process to the degree to which ‘socioeconomic’ subjects are covered in the medical curriculum.”

D-295.996, “Update on Development of Branch Campuses of International Medical Schools”

Our AMA will 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; Reaffirmed and Modified: CME Rep. 2, A-09	Retain, still relevant.

D-300.981, "Proposed Fee Increase by the Accreditation Council for Continuing Medical Education"

Our AMA will strongly urge the Accreditation Council for Continuing Medical Education (ACCME) to reconsider the proposed fee increase and, if the ACCME refuses to reconsider the proposed fee increase, our AMA will investigate and recommend ways by which physicians may receive appropriate, accredited continuing medical education other than through ACCME-accredited activities. (Res. 312, A-09)	Retain, still relevant; also, will be covered in more detail in a planned Council on Medical Education report.

D-305.963, "Securing Medicare GME Funding for Research and Ambulatory Non-Hospital Based Outside Rotations During Residency"

Our AMA will: 1. Advocate for the Centers for Medicare and Medicaid Services (CMS) (both federal Medicare and federal/state Medicaid) funding for the time residents and fellows spend in research, didactic activities, and extramural educational activities required for the Accreditation Council for Graduate Medical Education (ACGME) accreditation during their training. 2. Continue to work with organizations such as the Association of American Medical Colleges (AAMC) and the Council on Graduate Medical Education (COGME), to make recommendations to change current Graduate Medical Education (GME) funding regulations during residency training, which currently limit funding for research, extramural educational opportunities, and flexible GME training programs and venues. 3. Monitor any public and/or private efforts to change the financing of medical services (health system reform) so as to advocate for adequate and appropriate funding of GME. 4. Advocate for funding for training physician researchers from sources in addition to CMS such as the National Institutes of Health, the Agency for Healthcare Research and Quality, the Veterans Administration, and other agencies. (CME Rep. 4, I-08 Reaffirmed: CME Rep. 3, I-09 Modified: CCB/CLRPD Rep. 2, A-14)	Sunset; already accomplished, or superseded by other AMA policy. Items 1 and 2 have been addressed: For direct graduate medical education funds, CMS will count research time if it's part of the ACGME-accredited program; for indirect GME, CMS will count research time if it's associated with the treatment or diagnosis of a particular patient. The brochure "Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know," from the Association of American Medical Colleges," provides additional information on this topic: "16. What about the time I spend doing research? "For DGME payments, a hospital may count the time a resident spends performing research, including bench research, as long as the research takes place in the hospital and is part of an approved training program. For IME payments, a hospital may only count the time a resident spends performing clinical research that is associated with the treatment or diagnosis of a particular patient. If you were to take a year away from your residency training specifically to conduct research not required by your residency program, the research year would not count toward your IRP. For example, if you had completed three years of a general surgery program (a program with a five-year IRP), and you stepped away from the program for one year to do research not

	required by your program, you would still have two years remaining on your IRP when you returned to training after your research year." Item 3 is superseded by more comprehensive AMA policy, including D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education" and H-310.917, "Securing Funding for Graduate Medical Education." Item 4 is superseded by H-460.930, "Importance of Clinical Research," which reads in part: "(2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense."

D-305.996, "Coding for Services Involving Teaching Activity"

Our AMA will continue its efforts to develop the next generation of CPT coding, with attention to the coding needs of teaching physicians. (BOT Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09	Retain; still relevant.

D-305.997, "Training of Physicians Under Managed Care"

Our AMA will 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. (CME Rep. 4, A-99; Reaffirmed and Modified: CME Rep. 2, A-09	Sunset; superseded by H-295.995, "Recommendations for Future Directions for Medical Education," which reads in part: "(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education." Also superseded by H-285.974, "Residents Working with Managed Care Programs," which reads: "The AMA encourages managed care plans to allow residents to care for patients under faculty supervision in the inpatient and outpatient setting."

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; Reaffirmed: CME Rep. 2, A-09)	Sunset; superseded by the following policies: H-310.929, "Principles for Graduate Medical Education" "(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. 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. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The

	attending physician, or designate, must be available to the resident for consultation at all times." H-310.907, "Resident/Fellow Clinical and Educational Work Hours" "6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: … develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home." "o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations." In addition, the following from the AMA *Code of Medical Ethics* is relevant to rescission of this policy: Opinion 9.2.2, "Resident & Fellow Physicians' Involvement in Patient Care" "Physicians involved in training residents and fellows should … (f) Provide residents and fellows with appropriate faculty supervision and availability of faculty consultants, and with graduated responsibility relative to level of training and expertise."

H-310.945, "Graduate Medical Education Faculty Evaluations"

The AMA recommends that evaluations of residency program faculty should be done in a confidential manner, at least annually, and the areas evaluated should include teaching ability, clinical knowledge, scholarly contributions, attitudes, interpersonal skills, communication ability and commitment. Residency program directors should provide faculty members with a written summary of the evaluations. (CME Rep. 7, I-93; Reaffirmed and Modified: CME Rep. 2, A-05; Reaffirmed: CME Rep. 9, A-09)	Retain; still relevant.

D-310.956, "Transfer of Care for Resident and Fellow Physicians in Training"

Our AMA: (1) working with other organizations and stakeholders, will identify best practices including the presence, quality, and utilization of computerized systems for transfer of care in training programs in all specialties; (2) will encourage the ACGME to add to the Institutional Requirements a requirement that GME training institutions ensure that trainees in all specialties are provided with an effective, systematic approach for handoffs of clinical information and transfer of care between trainees within their institution; and (3) will advocate for the use of federal dollars in existing Health Information Technology (HIT) initiatives to sponsor systems that enable transfers of care that are integral to any well-functioning electronic medical record. (Res. 329, A-09)	Sunset, for reasons stipulated below. Item 1 is superseded by H-310.907, "Resident/Fellow Clinical and Educational Work Hours," which reads in part: "3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs..." Item 2 is already reflected in ACGME Institutional Requirements (effective July 1, 2018): *III.B.3. Transitions of Care: The Sponsoring Institution must:* *III.B.3.a) facilitate professional development for core faculty members and residents/fellows regarding effective transitions of care; and, (Core)* *III.B.3.b) in partnership with its ACGME-accredited program(s), ensure and monitor effective, structured patient hand-over processes to facilitate continuity of care and patient safety at participating sites. (Core)* Item 3 has been accomplished. HITECH (Health Information Technology for Economic and Clinical Health) Act funding for health information exchanges (HIEs) has run out, the Meaningful Use program is over, and the AMA successfully advocated to the Centers for Medicare & Medicaid Services (CMS) to focus its Performance Improvement efforts on interoperability. In fact, the newest HIE measures from CMS are on closing the referral loop—a core function in care transfer. Finally, the AMA has a significant number of other policies on broader advocacy efforts for interoperability.

D-310.957, "Resident and Fellow Benefit Equity During Research Assignments"

1. Our AMA will urge the Accreditation Council for Graduate Medical Education to require accredited sponsoring residency and fellowship training programs to continue to provide comparable benefits to resident and fellow physicians engaged in research activities that are required by either their sponsoring residency and fellowship training programs or residency review committees as if it were full-time clinical service. 2. Our AMA will collect data on resident and fellow physician benefits including resident and fellow physicians engaged in research activities. 3. Our AMA will, through the AMA Resident and Fellow Section, continue to work with residents and fellows and support training of biomedical scientists and health care researchers. 4. Our AMA will advocate that the Centers for Medicare & Medicaid Services include in an expanded cap the FEC count for GME payment formulas the time that resident and fellow physicians spend in research and other scholarly activities that is required by the ACGME. (CME Rep. 14, A-09)	Sunset, as described below. Item 1 would be anticompetitive, and unenforceable, based on an analogous ACGME requirement from the 1990s, which stated that all clinical residents at the same level be paid the same amount. This 1990s requirement was ruled anticompetitive by the U.S. Department of Justice at that time; item 1 would in all likelihood meet with the same decision. Despite research by AMA staff, it is unclear whether item 2 was accomplished; that said, it does not seem likely that it can be (or would be) accomplished in the future. Item 3 is *a priori* the role of the Resident and Fellow Section. Item 4 has been addressed: For direct graduate medical education funds, CMS will count research time if it's part of the ACGME-accredited program; for indirect GME, CMS will count research time if it's associated with the treatment or diagnosis of a particular patient. The brochure "Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know," from the Association of American Medical Colleges, provides additional information on this topic: "16. What about the time I spend doing research? "For DGME payments, a hospital may count the time a resident spends performing research, including bench research, as long as the research takes place in the hospital and is part of an approved training program. For IME payments, a hospital may only count the time a resident spends performing clinical research that is associated with the treatment or diagnosis of a particular patient. If you were to take a year away from your residency training specifically to conduct research not required by your residency program, the research year would not count toward your IRP. For example, if you had completed three years of a general surgery program (a program with a

	five-year IRP), and you stepped away from the program for one year to do research not required by your program, you would still have two years remaining on your IRP when you returned to training after your research year.”

D-310.960, “Timely Issuance of Social Security Number”

Our AMA will work with the United States government to provide a social security number in a timely fashion to foreign physicians with a work-related visa, upon lawful entry to the United States, for any purposes. (Res. 304, A-09)	Retain; still relevant.

H-350.968, “Medical School Faculty Diversity”

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; Reaffirmed: CME Rep. 2, A-09)	Sunset; superseded by D-200.985, “Strategies for Enhancing Diversity in the Physician Workforce,” which reads in part (relevant portions in italics): “1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and *d. Financial support programs to recruit and develop faculty members from underrepresented groups.”* *“4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.”*