REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1, June 2020

Subject:	Council on Medical Education Sunset Review of 2010 House of Delegates' Policies
Presented by:	Jacqueline A. Bello, MD, Chair
Referred to:	Reference Committee F and Amendments to Constitution and Bylaws (Ann R. Stroink, 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to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.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.

5. The most recent policy shall be deemed to supersede contradictory past AMA policies.

6. Sunset policies will be retained in the AMA historical archives.

The Council on Medical Education's recommendations on the disposition of the 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 listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: $1,000.

APPENDIX: RECOMMENDED ACTIONS ON 2010 AND OTHER RELATED HOUSE OF DELEGATES POLICIES

Policy Number, Title, Policy	**Recommended Action**

H-200.950, "Retraining Refugee Physicians"

Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories. (BOT Rep. 20, A-10)	Retain; still relevant.

H-200.959, "Support for the Funding of the National Health Service Corps"

The AMA supports the continuation of funding to the National Health Service Corps at least at the level originally appropriated in 1995. (Res. 241, A-95; Reaffirmed: CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; superseded by D-200.980, "Effectiveness of Strategies to Promote Physician Practice in Underserved Areas," which reads, in part: "1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations…." Also superseded by H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which reads, in part: "F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. "G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program."

H-200.984, "National Health Service Corps Reauthorization"

It is the policy of the AMA: (1) to support legislative efforts to revitalize and reauthorize the NHSC; and (2) to undertake efforts to assure that such legislation include increased funding for recruitment and retention efforts and adequate funding for both the loan repayment and scholarship programs.	Sunset; superseded by D-200.980, "Effectiveness of Strategies to Promote Physician Practice in Underserved Areas," which reads, in part: "1. Our AMA, in collaboration with relevant medical specialty societies, will continue to advocate for the following: (a) Continued federal and state

(Res. 120, A-90; Reaffirmed: Sunset Report and CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmation I-15)	support for scholarship and loan repayment programs, including the National Health Service Corps, designed to encourage physician practice in underserved areas and with underserved populations…." Also superseded by H-465.988, "Educational Strategies for Meeting Rural Health Physician Shortage," which reads, in part: "F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships. "G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program."

H-200.989, "National Health Service Corps"

The AMA believes that since a sufficient need for physician manpower is expected to continue to exist in certain areas of the U.S., continuation of assistance from the NHSC is justified. As long as this need continues, the AMA does not think it would be appropriate to deprive residents of certain areas of the U.S. of necessary medical services by diverting NHSC physicians to other countries. (CMS Rep. F, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CME Rep. 2, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; no longer relevant.

H-200.987, "Supply and Distribution of Health Professionals"

(1) Licensure, certification and accreditation should not be used for the purpose of regulating the supply of health professionals. (2) Health professions' curricula should emphasize the needs of underserved populations, including the poor, minorities, the chronically ill and disabled, and the geographically isolated. Decisions regarding the financing of health professions education should be based in part on the data and analyses of the national consortium on the supply and distribution of health professionals. (BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmation A-01; Modified: CME Rep. 2, I-03; Reaffirmation I-10)	Retain Clause 1, as it is still relevant; delete Clause 2. The first sentence of Clause 2 is superseded by H-295.874, "Educating Medical Students in the Social Determinants of Health and Cultural Competence." This policy should be revised to include mention of underserved populations, as follows: "Our AMA: (1) Supports efforts designed to integrate training in social determinants of health, ~~and~~ cultural competence, and meeting the needs of underserved populations across the undergraduate medical school curriculum

	to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models." The second sentence of Clause 2 is no longer relevant: For example, a "national consortium on the supply and distribution of health professionals" does not currently exist.

H-215.987, "Elimination of Hospital Medical Library"

It is the policy of the AMA through appropriate councils, to review current trends in scientific journal publishing and pricing and lend its support to efforts which will maintain Health Sciences Libraries at a level which ensures adequate learning resources for the present and future. (Sub. Res. 24, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10)	Retain; still relevant, with edits as shown below. "~~It is the policy of~~ Tthe AMA should work, through appropriate councils, to review current trends in scientific journal publishing and pricing and lend its support to efforts ~~which will~~ to maintain Health Sciences Libraries at a level ~~which~~ that ensures adequate learning resources for the present and future."

H-220.996, "Private Patients and the Responsibility of the Attending Physician in a Teaching Hospital Setting"

Our AMA opposes mandatory delegation of diagnosis and treatment of private patients primarily to housestaff physicians in teaching hospitals and recommends that (1) refusal to delegate care of private patients to housestaff not be grounds for reduction or termination of privileges; (2) the patient's own private physician be responsible for his care; and (3) JCAHO assure that accreditation standards maintain the right of free choice by patients to have care provided by his own physician. (Sub. Res. 131, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset. The Academic Physicians Section or another AMA section will be asked to review the policy and consider an updated version, if needed.

H-255.969, "Create Local Observership Programs"

Our AMA encourages physician preceptors, medical associations, and medical organizations to establish local observership programs by utilizing the IMG Observership Guidelines and Evaluation Tools. (Res. 307, A-10)	Retain; still relevant.

H-255.975, "J-1 Exchange Visitor Program (J-1 Visa)"

1. Policy of the AMA states: the purpose of the physician J-1 Visa Exchange Program is to ameliorate physician specialty shortages in other countries; and the AMA will work to correct the problems of inconsistency, lack of accountability, and non-compliance in the administration of the physician J-1 Visa Exchange Program. 2. Our AMA supports a model employment contract specific to J-1 Visa Waiver physicians. (CME Rep. 2, A-97; Modified and Reaffirmed: CME Rep. 2, A-07; Appended: Res. 304, A-10)	Retain; still relevant.

H-255.978, "Unfair Discrimination Against International Medical Graduates"

It is the policy of the AMA to take appropriate action, legal or legislative, against implementation of Section 4752(d) of the OBRA of 1990 that requires international medical graduates, in order to obtain a Medicaid UPlN number, to have held a license in one or more states continuously since 1958, or pass the Foreign Medical Graduate	Retain; still relevant.

Examination in Medical Sciences (FMGEMS), or pass the Educational Commission for Foreign Medical Graduates (ECFMG) Examination, or be certified by ECFMG. (Res. 123, I-90; Reaffirmation A-00; Reaffirmed: CME Rep. 2, A-10)	

D-255.997, "Alternate Licensure Protocols for IMGs"

Our AMA will actively support the Florida Medical Association in pursuing legislation that would require the Florida Department of Health to prevent and negate separate criteria for International Medical Graduates to become licensed as Florida physicians. (Res. 311, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; no longer relevant. This policy resulted from a resolution related to approximately 400 Cuban refugee physicians seeking to practice medicine in the U.S. (in Florida, in particular). As noted in a 2000 *New York Times* article, "To accommodate them, the Florida Legislature, at the urging of the Cuban-American Caucus, has established a separate test for this group, in the hopes of making it easier to pass. It has placed less emphasis on pure science and more on treatment and diagnosis, for example, and made special courses available to help these immigrants prepare for the test." Also, superseded by H-200.950, "Retraining Refugee Physicians": "Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories."

H-275.921, "Licensure for Physicians Not Engaged in Direct Patient Care"

Our AMA: (1) opposes laws, regulations, and policies that would limit the ability of a physician to obtain or renew an unrestricted state or territorial medical license based solely on the fact that the physician is engaged exclusively in medical practice which does not include direct patient care; (2) advocates that the Federation of State Medical Boards support provision of unrestricted state or territorial medical licenses to physicians engaged in medical practice that does not include direct patient care; (3) urges constituent state and territorial medical societies to advocate with their respective medical boards to establish policy that will facilitate provision of unrestricted state or territorial medical licenses to physicians in medical practice that does not	Retain; still relevant.

include direct patient care; and (4) opposes activities by medical licensure boards to create separate categories of medical licensure solely on the basis of the predominant professional activity of the practicing physician. (Res. 923, I-10)	

H-275.958, "Discouraging the Use of Licensing Exams for Internal Promotion in Medical Schools"

It is the policy of the AMA to use its representatives on key national medical education committees to encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase. (Res. 289, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant, with edits as shown below, as AMA representatives to external medical education committees have a fiduciary responsibility to that organization, not to the AMA. "It is the policy of the AMA to ~~use its representatives on key national medical education committees to~~ encourage the discontinuation of the use of the USMLE Step 1 Exam as a requirement for the promotion of medical students to the clinical phase."

H-280.998, "Resident Medical Training in Nursing Homes for Geriatric Patients"

Our AMA endorses the concept of affiliation between nursing home facilities for geriatric patients and resident training programs for the development of clinical experience in such facilities where feasible. (Sub. Res. 12, I-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; still relevant, but append to D-295.969, "Geriatric and Palliative Care Training For Physicians," to read as follows: "Our AMA: ~~will~~ 1) encourages geriatrics and palliative care training for physicians caring for elderly and terminally ill patients in long-term care facilities; and 2) endorses the concept of affiliation between nursing home facilities for geriatric patients and residency/fellowship programs, where feasible, for the development of physicians' clinical experience in such facilities."

H-295.873, "Eliminating Benefits Waiting Periods for Residents and Fellows"

Our AMA: (1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training; (2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees' first date of employment and to aggressively enforce this requirement; and	Retain; still relevant.

(3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education. (4) encourages the Accreditation Council for Graduate Medical Education to request that sponsoring institutions offer to residents and fellows a range of comparable medical insurance plans no less favorable than those offered to other institution employees. (BOT Action in response to referred for decision Res. 318, A-06; Appended: CME Rep. 5, A-10)	

H-295.886, "Progress in Medical Education: Evaluation of Medical Students' and Resident Physicians' Professional Behavior"

AMA policy is that the educational programs for medical students and resident physicians must include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training. (CME Rep. 3, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; still relevant, but append to D-295.983, "Fostering Professionalism During Medical School and Residency Training," to read as follows: "(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, to include an evaluation of professional behavior, carried out at regular intervals and employing methods shown to be valuable in adding to the information that can be obtained from observational reports. An ideal system would utilize multiple evaluation formats and would build upon educational experiences that are already in place. The results of such evaluations should be used both for timely feedback and appropriate interventions for medical students and resident physicians aimed at improving their performance and for summative decisions about progression in training."

H-295.957, "Use of Animals in Medical Education"

Our AMA has adopted the following guidelines on the use of animals in medical school curricula and continuing medical education courses: (1) Where appropriate, medical school faculty should consider using non-animal models in education activities; when animals are used in the curriculum, education goals should be clearly stipulated. (2) Each medical school should disseminate a policy statement to students before matriculation regarding their participation in educational experiences involving animals. (3) All educational experiences involving animals should have the approval of the institutional Animal Care and Use Committee. (4) Involved faculty should discuss with students the learning objectives of any educational experience that utilizes animals, and faculty should remain available throughout the laboratory exercise for advice and guidance on the conduct of the educational experience. (5) All educational experiences involving animals should be carried out in a humane manner without inflicting pain on the animal. This includes the appropriate use of anesthetic and analgesic drugs.	Retain; still relevant. Although now encompassed in research regulations and laws for animal care, it is appropriate for the AMA to maintain this ethical stance.

(6) At the conclusion of study, animals should be euthanized in the manner described by the American Veterinary Medical Association. (CSA Rep. A, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	

H-295.959, "Departments of Family Practice in all LCME Approved Medical Schools"

Our AMA urges the LCME to strongly encourage every medical school without a Department of Family Practice to develop one. (Res. 59, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant, with edits as shown below to policy and title. Although, as noted in a 2016 article in STAT, "only 10 medical schools in the nation … don't have a department of family medicine, according to the American Academy of Family Physicians," this list includes several prominent institutions, such as Harvard, Yale, Johns Hopkins, and Columbia. Note: The LCME does not encourage or mandate specific department structure, so it has been removed from the revision. In addition, the language of the policy's title has been revised for precision. "Departments of Family ~~Practice~~ Medicine in all LCME ~~Approved~~Accredited Medical Schools" "Our AMA urges ~~the LCME to strongly encourage~~ every medical school without a Department of Family ~~Practice~~ Medicine to develop one."

H-295.960, "Broadly Based Clinical Experience and Clinical Proficiency Standards"

It is the policy of the AMA: (1) to direct its representatives on the LCME to continue to monitor the educational content of the final year of educational programs accredited by the LCME so that the standards, and their application to accredited programs, will provide a broad clinical experience; and (2) to reaffirm existing policy that the first year of graduate medical education should provide the resident physician with a broad clinical experience. (CME Rep. H, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; still relevant, but superseded by other policies, as noted below. In addition, there are no AMA representatives to the LCME, and the LCME does not monitor programs' educational content. Clause 1 is superseded by H-295.895 (2), "Progress in Medical Education: Structuring the Fourth Year of Medical School," which reads: "(2) The third and fourth years as a continuum should provide students with a broad clinical education that prepares them for entry into residency training."

	Clause 2 is superseded by H-295.995 (19), "Recommendations for Future Directions for Medical Education," which reads: "(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training."

H-295.966, "Medical School Honor Codes"

Our AMA urges the LCME to facilitate the development of honor codes by medical schools. (CME Rep. D, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset. The LCME doesn't "facilitate" this, and schools are required by LCME standards to define expectations for professional conduct. In addition, the LCME requires the creation of professionalism policies related to appropriate behavior on the part of students and faculty, which covers the same ground as an honor code.

H-295.968, "Training Physicians for the 21st Century"

Our AMA approves the concept of undertaking focused studies of medical education, with the participation of other appropriate organizations, at such time as adequate funding can be obtained. (CME Rep. D, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; superseded by the AMA's work through the Accelerating Change in Medical Education initiative.

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. (CME Rep. B, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CME Rep. 2, A-05; Appended: Res. 318, A-10)	Sunset; still relevant but superseded by the following policies (with proposed edits as shown). For clause 1: D-295.321, "Health Care Economics Education" "Our AMA, along with the Association of American Medical Colleges, Accreditation Council for Graduate Medical Education, and other entities, will work to encourage education in health care economics during the continuum of a physician's professional life, ~~starting in~~ including undergraduate medical education, graduate medical education and continuing medical education." For clause 2: H-310.953, "Practice Options and Skills Curriculum ~~for Residents~~ in Medical Education"

	"The AMA will assist medical societies, medical schools, and residency programs in the development of model curricula ~~for resident physicians and those entering practice~~ regarding practice options and management skills, including information on CPT and ICD coding, as well as RBRVS and RUC."

D-295.984, "Progress in Medical Education: Evaluation of Medical Students' and Resident Physicians' Professional Behavior"

Our AMA will: (1) encourage research and collect information on methods for evaluating the objectives related to professional behavior, and share this information with the medical education community; and (2) offer to work with other organizations, such as the Association of American Medical Colleges, the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the Federation of State Medical Boards, and the American Board of Medical Specialties, to develop methods and strategies for the evaluation of professional behavior. (CME Rep. 3, I-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; this is encompassed in the work of the AMA's Accelerating Change in Medical Education initiative.

H-300.953, "Content-Specific CME Mandated for Licensure"

(1) The AMA, state medical societies, specialty societies, and other medical organizations should reaffirm that the medical profession alone has the responsibility for setting standards and determining curricula in continuing medical education. (2) State medical societies should establish avenues of communication with groups concerned with medical issues, so that these groups know that they have a place to go for discussion of issues and responding to problems. (3) State medical societies should periodically invite the various medical groups from within the state to discuss issues and priorities. (4) State medical societies in states which already have a content-specific CME requirement should consider appropriate ways of rescinding or amending the mandate. (CME Rep. 6, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 12, A-10)	Retain; still relevant.

H-300.976, "Unification of Education Credits"

It is the policy of the AMA to develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies. (Res. 102, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant.

H-300.980, "Focused Continuing Education Programs for Enhanced Clinical Competence"

1. The AMA encourages state and, where appropriate, local medical societies to respond to the needs of physicians who have been identified as requiring focused continuing medical education. 2. The AMA encourages state and county medical societies to cooperate with organizations and agencies concerned with physician competence, such as state licensing boards, and to assist in providing opportunities for physicians to participate in focused continuing education programs. 3. The AMA supports the collection and dissemination of information on focused continuing medical education programs that have been developed or are in the process of development. 4. Our AMA recommends that organizations with responsibilities for patient care and patient safety request physicians to engage in content-specific educational activities only when there is a reasonable expectation that the CME intervention will be appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physicians' practice. (CME Rep. C, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CME Rep. 2, A-08; Appended: CME Rep. 12, A-10)	Retain; still relevant.

H-300.994, "Support of Voluntary Continuing Medical Education"

Our AMA supports individual physician responsibility for self-education. (Res. 138, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 12, A-10)	Retain; still relevant.

H-300.996, "Reaffirmation of Support for Continuing Medical Education"

Our AMA supports investing funds in effective self-instructional educational programs that are within the budget and are potentially self-supportive. (Sub. Res. 122, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant.

H-300.997, "'Medical Education' Travel"

Our AMA (1) deplores excessive charges for continuing medical education programs which exploit physicians or distort the real purposes of education programs; (2) encourages state society accrediting agencies to consider the impact of the cost of the accreditation process on program charges; and (3) supports making a concentrated effort to acquaint physicians with programs that will help them meet their particular educational needs at a reasonable cost. (Sub. Res. 84, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant.

H-300.998, "Continuing Medical Education"

Our AMA continues to encourage physicians to voluntarily participate in continuing medical education. (Sub. Res. 13, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; still relevant, but superseded by H-300.994, "Support of Voluntary Continuing Medical Education," which reads, "Our AMA supports individual physician responsibility for self-education."

H-305.934, "Medical School Tuition and Opposition to Tax Increases"

1. Our American Medical Association opposes the imposition of mid-year and retroactive tuition increases at both public and private medical schools. 2. Our AMA opposes tuition taxes and any other attendance-based taxes by any government entity.	Sunset; still relevant, but append to D-305.983, "Strategies to Combat Mid-year and Retroactive Tuition Increases," to read as follows: "Our AMA will: (1) assist state medical societies in advocacy efforts in opposition to mid-year and retroactive tuition increases,

(CME Rep. 2, I-02; Reaffirmed: CME Rep. 3, I-03; Appended: Res. 905, I-10)	tuition taxes, and any other attendance-based taxes by any government entity at both public and private medical schools; (2) make available, upon request, the judicial precedent that would support a successful legal challenge to mid-year tuition increases; and (3) continue to encourage individual medical schools and universities, federal and state agencies, and others to expand options and opportunities for financial aid to medical students."

H-305.969, "Financial Information Requirements for Independent Medical Students"

Our AMA urges the HHS to abolish its requirement that independent students submit parental financial information when applying for financial assistance, consistent with the current policy of the Department of Education. (Sub. Res. 250, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; see the following information from the Student Financial Aid Guidelines for Health Professions Programs, related to the Primary Care Loan (PCL) Program (December 2011: "[T]he Affordable Care Act changed the parental financial information requirement for independent students who want PCLs [Primary Care Loans]. As of March 23, 2010, the requirement for independent students to provide parental financial information to determine financial need is eliminated. However, at its discretion, a school may still want to require parental financial information for independent students seeking a PCL. For this program, an independent student is defined as a student who is at least 24 years of age and can prove that he or she has been independent for a minimum of 3 years." [Section 5201(b) of the Affordable Care Act]

D-305.994, "Postgraduate Medical Education Reimbursement"

Our AMA: (1) will study the formula for funding graduate medical education that is used by Medicare, and make recommendations to ensure that all sites where resident physicians are trained are included in the funding formula; and (2) policies related to the mechanisms for the funding of graduate medical education be reviewed and, if appropriate, be consolidated. (Sub. Res. 301, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset. The AMA has frequently studied the Medicare formula for funding graduate medical education and continues to do so. The phrase "make recommendations to ensure that all sites where resident physicians are trained are included in the funding formula" is superseded by D-305.967 (6), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," which reads: "6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board

	certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.)." Finally, clause 2, which asks that "policies related to the mechanisms for the funding of graduate medical education be reviewed and, if appropriate, be consolidated," is accomplished periodically through this report as well as other AMA Council and Board of Trustees' reports that consider medical education funding.

D-305.995, "Physician Workforce Planning and Physician Retraining"

(1) Our AMA will raise the awareness of groups using the model of adjusting entry-level residency positions to control the physician workforce of the substantial effect of retraining and changes in choice of specialty training on the number of filled entry-level positions. (2) Our AMA will collect data on access to health care by specialty and geographic location to assist in ongoing workforce planning initiatives. (3) A new model for workforce planning be developed to address the needs of the public for access to health care and the subsequent impact on the needs of teaching institutions to maintain the quality of their educational programs in considering the number of entry-level residency positions. (CME Rep. 2, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; superseded by D-305.967, "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education." Relevant segments include: "18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes." "20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education." Also superseded by D-305.958, "Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy." Relevant segments include the following: "4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages." "5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians."

H-305.999, "Financial Aid to Medical Students"

Our AMA urges physicians to contribute to the AMA Foundation for support of medical education and provision of scholarships to medical students. (Res. 6, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10)	Retain; still relevant.

H-310.914, "Appropriate Use of 360 Degree Evaluations"

Our AMA will: (1) encourage the Accreditation Council on Graduate Medical Education (ACGME) to study mechanisms used by residency programs to evaluate resident performance in the ACGME six general competencies, including 360-degree evaluation tools; and (2) encourage the ACGME to develop standards for the use of 360-degree evaluations, including a determination of their validity in resident assessment, and methods to ensure that the content of individual evaluations remains confidential and legally protected. (Res. 316, A-10)	Sunset; reflected in ACGME Common Program Requirements, as follows: V.A.1.c) The program must provide an objective performance evaluation based on the Competencies and the specialty-specific Milestones, and must: V.A.1.c).(1) use multiple evaluators (e.g., faculty members, peers, patients, self, and other professional staff members)….

H-310.915, "Securing Funding for Graduate Medical Education"

Our AMA will: (1) actively advocate for strong physician representation and significant participation in any proposed health-care workforce advisory committees, demonstration projects, or workforce assessments, since PL 111-148 calls for a "Health Workforce Commission"; (2) continue to advocate for adequate and sustained federal funding of pediatric residency programs independent of Medicare payments; and (3) encourage sponsors of graduate medical education (GME) training programs to use any refunded Federal Insurance Contributions Act (FICA) dollars they receive to enhance their GME training programs. CME Rep. 15, A-10	Sunset. Clause 1 is no longer relevant, as the proposed national health workforce commission of PL 111-148 (the Patient Protection and Affordable Care Act of 2010) was never funded. Clause 2 is superseded by D-305.973 (1.e), "Proposed Revisions to AMA Policy on the Financing of Medical Education Programs," which directs our AMA to work with "the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to… (e) stabilize funding for pediatric residency training in children's hospitals." Clause 3 is no longer relevant, as the refunded FICA monies have been distributed by the IRS. (In 2010, the IRS announced that medical residents may be eligible for a refund for the FICA (Social Security and Medicare) taxes withheld prior to April 1, 2005, and established a process by which refunds were requested by institutions on behalf of former residents.)

D-310.958, "Fellowship Application Reform"

1. Our AMA will: (a) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training; and (b) continue to encourage all subspecialties to use the same application cycle and such application cycle should commence only in the final year of residency for programs of less that 5 years, or in the final 2 years of residency for programs of 5 years or longer. 2. Our AMA will work with relevant stakeholders to study the impact of delayed fellowship start dates after July 1 to evaluate the benefits and drawbacks for all interested parties. (CME Rep. 5, A-09; Appended: Res. 303, A-18)	Retain, still relevant, with minor edit as shown below. 1. Our AMA will: (a) continue to collaborate with the Council of Medical Specialty Societies and other appropriate organizations toward the goal of establishing standardized application and selection processes for specialty and subspecialty fellowship training; and (b) continue to encourage all subspecialties to use the same application cycle and such application cycle should commence only in the final year of residency for programs of less ~~that~~ than 5 years, or in the final 2 years of residency for programs of 5 years or longer. 2. Our AMA will work with relevant stakeholders to study the impact of delayed fellowship start dates after July 1 to evaluate the benefits and drawbacks for all interested parties.

D-310.965, "Credentialing Materials: Timely Submission by Residency and Fellowship Programs"

1. Our AMA: (a) encourages residency programs and fellowship programs to properly complete and promptly submit verification of resident education/training on credentialing and re-credentialing forms to the requesting agency within thirty days of the request; and (b) encourages the Accreditation Council for Graduate Medical Education to add to the accreditation standards for residency and fellowship programs and to the Institutional Program Requirements the requirement of the proper completion and prompt submission of verification of resident education/training on credentialing and re-credentialing forms to the requesting agency within thirty days of the request. 2. Our AMA will work with the Federation of State Medical Boards, American Osteopathic Association and the Accreditation Council for Graduate Medical Education to develop a model form that residency programs can use to document resident performance, dates of participation, and any disciplinary measures imposed, to be maintained in the resident's	Sunset. Clause 1 is now part of the ACGME Common Program Requirements: The program director must: II.A.4.a).(14) document verification of program completion for all graduating residents within 30 days; II.A.4.a).(15) provide verification of an individual resident's completion upon the resident's request, within 30 days; Clause 2 has been accomplished, through development of the Verification of Postgraduate Medical Education form, available via the Federation of State Medical Boards website.

training file and used when future requests are submitted for evaluation of resident performance. (Res. 311, A-08; Appended: Sub. Res. 308, A-10)	

H-310.968, "Opposition to Centralized Postgraduate Medical Education"

Our AMA (1) continues to support a pluralistic system of postgraduate medical education for house officer training; and (2) opposes the mandatory centralization of postgraduate medical training under the auspices of the nation's medical schools. (Res. 69, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset. Clause 1 is superseded by D-305.967 (6), "The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education," which reads: "6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.)." Clause 2 is no longer relevant, as (unlike in the late 1990s, when the initial resolution was drafted) there are no plans for "mandatory centralization" of GME in medical schools.

H-310.970, "Mandatory Helicopter Flight for Emergency Medical Residents in Training"

Our AMA urges residency training programs that require helicopter transport as a mandatory part of their residency to notify applicants of that policy prior to and during the interview process. (Res. 239, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant.

H-310.972, "Residency Review Committee Representation and Requirements"

Our AMA (1) supports obtaining community practitioners representation on the Residency Review Committees (RRC); and (2) urges RRC members to be mindful of the concerns of community hospital residency programs in addressing residency program requirements and to become more representative of community hospital residency programs. (Res. 219, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Retain, with edits as shown. Our AMA (1) supports obtaining community practitioners representation on ~~the Residency~~ ACGME Review Committees (~~R~~RCs); and (2) urges ~~R~~RC members to be mindful of the concerns of community hospital residency programs in addressing residency program requirements and to become more representative of community hospital residency programs.

D-310.994, "Intern and Resident Work Standards"

Our AMA: (1) will support the various standards of Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committees as a template for reasonable resident work conditions, pending further data; and (2) will stress the consideration of patterns and trends of program violations of ACGME requirements, and affirm the recommendations of Council on Medical Education Report 3, A-00, that recommended various alternatives to enforce compliance with requirements, including the shortening of the cycle for review of programs that receive unfavorable Institutional Reviews. (Sub. Res. 306, I-00; Appended: CME Rep. 2, A-10)	Sunset; no longer relevant, and superseded by H-310.907, "Resident/Fellow Clinical and Educational Work Hours."

D-310.995, "Enforcement of ACGME Requirements"

(1) The ACGME be asked to distribute the alternatives suggested in this report to each of the Residency Review Committees (RRC) and the Institutional Review Committee for their consideration and comment as mechanisms to enforce compliance with requirements. (2) Our AMA representatives be requested to ask the ACGME and the RRCs to discuss mechanisms included in this report to enhance the enforcement of Institutional and Program Requirements without increasing the risk of the withdrawal of accreditation. (3) Our AMA representatives be requested to ask the ACGME and the RRCs to determine any additional information regarding program evaluations that can be added to the ACGME web site and that they encourage the ACGME to simplify that web site to facilitate the retrieval of information. (4) Our AMA, through the Medical Student Section and the Resident and Fellow Section, will provide medical students and residents a guide to interpreting the ACGME Web site as it relates to the various levels of accreditation and the length of the survey cycle. (CME Rep. 3, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; no longer relevant, and generally accomplished, in all likelihood.

D-383.996, "Impact of the NLRB Ruling in the Boston Medical Center Case"

Our AMA: (1) representatives to the ACGME be encouraged to ask the ACGME to review the Institutional Requirements and make recommendations for revisions to address issues related to the potential for resident physicians to be members of labor organizations. This is particularly important as it relates to the section on Resident Support, Benefits, and Conditions of Employment; and (2) through the Division of Graduate Medical Education, the Resident and Fellow Section, and the Private Sector Advocacy Group develop a system to inform resident physicians, housestaff organizations, and employers regarding best practices in labor organizations and negotiations. (CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10)	Sunset; the topic is still relevant, but this policy is superseded by other more relevant policies, including H-383.999 (2, 3), "Physician Negotiation," which notes: "2. Our AMA continue to support the development of independent house staff organizations for employed, resident and fellow physicians and support the development and operation of local negotiating units as an option for all employed, resident and fellow physicians authorized to organize labor organizations under the National Labor Relations Act. "3. Our AMA continues to advance its private sector advocacy programs and explore, develop, advocate, and implement other innovative strategies, including but not limited to initiating litigation, to stop egregious health plan practices and to help physicians level the playing field with health care payers." In addition, D-383.977, "Investigation into Residents, Fellows and Physician Unions," states that "Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment."

H-405.984, "Physician and Public Attitudes on Medicine as a Career"

Our AMA (1) supports continuation of its many efforts to address issues, such as professional liability and excessive regulation and interference by third parties, which contribute to the professional dissatisfaction expressed by some physicians; (2) supports continuation of its efforts to communicate to students, from elementary through college level, the rewards of a career in medicine, emphasizing the positive aspects of a career in medicine; (3) supports utilizing the Association's communications resources to make the 40 percent of the physician population who are dissatisfied with medicine as a career aware of the impact they are having on the career decisions of potential medical students and the	Sunset; the policy, which was originally adopted in 1989, has been superseded by and incorporated into AMA's multi-departmental work to promote the value of a career in medicine and enhance the joy of medical practice by addressing administrative and regulatory burdens that can lead to physician burnout.

implications that this has for the future of medicine; and (4) encourages the majority of physicians who feel positive about their career, and who understand that the profession is both challenging and rewarding, to aggressively convey, on a personal basis, their thoughts on the attributes of medicine as a career to students, the media, and other interested parties. (CLRPD Rep. D, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	

H-405.987, "Identification of Board Certified Physicians"

Our AMA urges physicians to identify themselves by stating the full name of their certifying board. (Res. 99, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10)	Retain; still relevant. This is reflected in the AMA's "Truth in Advertising" campaign, which notes the following (see page 13): "A medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or 'board certified,' unless all of the following criteria are satisfied: (a) The advertisement states the full name of the certifying board…."

H-435.946, "Liability Coverage for Medical Students Completing Extramural Electives"

Our AMA: (1) supports the continuance of the AAMC online Extramural Electives Compendium (EEC) database as a resource for information on medical school electives, including liability insurance fees; and (2) will work with the AAMC to encourage medical schools to provide sufficient medical liability insurance for their own students completing electives at US Medical Doctor and Doctor of Osteopathy granting medical schools. (CME Rep. 9, A-10)	Retain; still relevant.